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IN THIS ISSUE

Surgery of Biliary Tract
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Baby Feeding
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Massive Hemorrhage
Fred E. Manulis

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CONTENTS

SCIENTIFIC ARTICLES

Surgery of the Biliary Tract: A Personal Experience with Eight Hundred and Fifty Consecutive Cases in Private Practice, Lon Grove, M. D. 95

Management of Massive Hemorrhage from the Upper Part of the Gastrointestinal Tract, Fred E. Manulis, M.D. 103

A New Concept of Baby Feeding, Walter W. Sackett, Jr., M.D. 109

Some Observations on the Interrelationships of Allergy and Diseases of the Chest, Clarence Bernstein, M.D., and Solomon D. Klotz, M.D. 113

ABSTRACTS OF MEDICAL ARTICLES

Drs. Gerard Raap, Donald F. Marion, Sidney Grau, James L. Gouaux, M. Eugene Flipse, Eugene L. Jewett, Arthur J. Butt, Joseph Q. Perry and Kenneth Phillips 116

EDITORIALS AND COMMENTARIES

August Anniversaries 120

The Korean Medical Experience 122

A Decade of Health Progress in Florida 122

Novel Diagnostic Method 123

The War Prisoner Medical Burden in Korea 123

The Florida Cancer Council 124

The National Fund for Medical Education 125

Postgraduate Medical Education 126

GENERAL FEATURES

Officers and Committees 118

Your Blue Shield 126

State Board of Health 127

New Members 127

Births and Deaths 127

State News Items 128

Wanted — For Sale 129

Component Society Notes 129

Obituaries 130

Woman's Auxiliary 134

Books Received 136

Schedule of Meetings 145

List of County Medical Societies, Presidents and Secretaries 146

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Surgery of the Biliary Tract: A Personal Experience with Eight Hundred and Fifty Consecutive Cases in Private Practice

LON GROVE, M.D.
ATLANTA

This report of surgery of the biliary tract is presented to record the efforts of myself and my associates in this field for the past thirty years, to acquaint our colleagues with the type of procedures employed, and to stimulate suggestions for improvement. Grateful acknowledgment is given to our medical confreres for their aid and cooperation in the diagnosis and treatment of the cases included in this report. By far the larger number of diagnostic studies have been made before the patient has been referred to us. As would be expected, the volume of work has gradually increased, and in 656, or 77 per cent, of the cases the patient has been operated on during the last ten years. Of greater importance and interest is the fact that the mortality has decreased, and during the last ten years has been 0.45 per cent. As will be pointed out in the body of this paper, numerous factors have contributed to this gradual decrease in surgical mortality. Chief among these are more careful evaluation and preparation of the patient; a more effective means of combating infection, especially by the use of antibiotics in recent years; a better understanding and more accurate control of electrolyte and fluid balance; better knowledge and fulfilment of the nutritional requirements of the seriously ill and jaundiced patient; and greater emphasis on the prevention rather than the treatment of postoperative complications.

History of Biliary Surgery[1]

The contemporary operative treatment of surgery of the biliary tract began with the pioneer work of Ephraim McDowell (1771-1830), the first surgeon to open the abdomen for the purpose of removing an ovarian cyst. McDowell's work in ovariotomy laid the foundation for operation on the biliary tract. Prior to McDowell's work, good descriptions of gallbladders were given by Mathew Baillie and Louis Petit in Europe and Samuel Sharp in London. The American pioneer of cholecystostomy was an Indiana man, John S. Bobbs, who in 1867 explored an abdominal tumor which proved to be a distended gallbladder.

Theodor Kocher, of Berne, Switzerland, was the first to perform successfully a two stage operation using the antiseptic technic (1878). William Keen, of Philadelphia, completed an operation also in 1878, unsuccessfully. Marion Sims deliberately operated for gallstones in Paris that same year. From Sims we derived the procedure name of "cholecystostomy." The patient did not survive. Lawson Tait, of Birmingham, England, and Joseph Price, of Philadelphia, were other pioneers who operated deliberately for gallstones in those early days. It will be remembered, only the stones were removed. Cholecystectomy had been done experimentally on dogs, but the first cholecystectomy on a human was executed by Johann August Langenbuch in 1882. Thus, we find biliary surgery is a comparatively recent development in the surgical world.

Incidence of Disease in the Biliary Tract

Blackwell found evidence of gallbladder disease in 16.4 per cent of 6,000 routine autopsies, and it was his opinion that in persons past 30 years of age, more than one half had diseased gallbladders and of this number approximately one fifth had gallstones. Eliason thought that probably 15 per cent have biliary disease. Graham[2] stated that calculous cholecystitis occurs in 20 to

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From the Department of Surgery, Emory University School of Medicine, Atlanta, Ga.

25 per cent of adults and probably an equal number of persons have cholecystitis without stones. These various figures impress upon us the frequency of disease of the biliary tract, and, as a result, we are impressed with the importance of certain questions, namely, the accuracy in diagnosis, the indications for operation, the effect if the gallbladder is not removed, and whether the present day mortality rate justifies cholecystectomy in the absence of highly active symptoms, particularly gallbladder colic.

This report is based on an experience of 850 consecutive operations on the biliary tract in private patients, and it begins with the second epoch of biliary surgery, cholecystectomy. The argument for cholecystostomy versus cholecystectomy, which occupied such a prominent place in practically all surgical meetings from 1910 to 1915, was beginning to be settled because of the realization that the disease was primarily in the wall of the gallbladder.

Diagnosis

As shown in this report, the cases in which the patient was operated on between 1920 and 1930 revealed too large a percentage of incorrect diagnoses evaluated by present day standards (figs. 1-4). This high percentage occurred because there was no accurate method of diagnosing disease of the gallbladder. It was not until Graham and Cole,[3] in 1924, introduced the cholecystogram, as used today, that we had a really reliable aid in the diagnosis of disease of the gallbladder. This fact is illustrated in our summary of the cases from 1930 to 1950, which shows only 10 per cent of gallbladders removed in this period were without stones, and many of these were cases of acute cholecystitis.

There are no characteristic symptoms that differentiate the types of cholecystitis in the early period of the disease. The chronically inflamed gallbladder, the catarrhal gallbladder, the strawberry gallbladder, and cholesterosis all show practically the same clinical manifestations. Both in the acute and subacute conditions variable symptoms occur, and frequently there is no evidence of fever or leukocytosis, even in the presence of stones. The hydropic gallbladder frequently produces comparatively mild symptoms, while manifestations of an acutely inflamed gallbladder are not infrequently fulminating. It is in the gangrenous gallbladder we encounter the more characteristic clinical manifestations: high tempera-

MORTALITY	1921 1930	1931 1940	1941 1950	Total
NUMBER CASES	41	153	656	850
MORTALITY	3	2	3	8
% MORTALITY	7.3%	1.3%	.45%	.94%

Figure 1.

MORTALITY 1921-1930

1. 7th P.O. day. Chronic cholecystitis with stones, cholecystectomy, acidosis, acute appendicitis.
2. 3rd P.O. day. Acute cholecystitis with stones, cholecystectomy, cardiac.
3. 12th P.O. day. Postoperative stricture common duct, jaundice, exploration common duct.

Figure 2.

MORTALITY 1931-1940

1. 1st P.O. day. Chronic cholecystitis with stones, jaundice, common duct stones, cholecystectomy, exploration common duct, cardiac, shock.
2. 3rd P.O. day. Cholecystectomy 6 mo. previously. Common duct stone, jaundice, exploration common duct, choledochoduodenostomy, lower nephron syndrome.

Figure 3.

MORTALITY 1941-1950

1. 7th P.O. day. Chronic cholecystitis with stones, carcinoma liver, cholecystectomy.
2. 7th P.O. day. Chronic cholecystitis with stones, cholecystectomy, exploration common duct, acute pancreatitis, lower nephron syndrome.
3. 3rd P.O. day. Chronic cholecystitis with stones, cholecystectomy, leukemia, pneumonia.

Figure 4.

ture, high leukocyte count, with definite evidence of peritoneal irritation, and not infrequently a palpable gallbladder.

Tumors of the gallbladder cause no characteristic symptoms by which a diagnosis can be made. Papilloma is the one type of tumor that can at times be demonstrated by roentgen examination. There were 7 cases in this series (fig. 5). A review of the literature raises considerable question as to the relationship between papilloma and malignant disease. Malignant lesions occurred in 13 cases, or 1.8 per cent, in this series (fig. 5). Except in the advanced stages, manifested by metastasis to the liver, the symptoms were not indicative of a malignant condition, and the diagnosis was made only at the time of exploration.

The most convincing evidence of gallbladder disease is the cholecystogram. The cholecystogram is the most important single test in establishing a diagnosis. To quote Dr. Ted F. Leigh, Chief of Radiology at Emory University Hospital:

"The two positive x-ray findings indicative of gallbladder disease are the demonstration of stones and poor concentration, or complete absence of the dye. For accurate interpretation of a gallbladder series, films must be free of fog, and developing solutions must be fresh. In making the films the technician must cone down on the film and should seek to give optimum exposure in compliance with the patient's size, even if it means several repeats on a single film. Too often, because of poor technique, a normal gallbladder is interpreted as pathological, one of the most common causes of error in diagnosis.

"Radiologists feel that a minimum of four to six films is necessary, including some in the upright as well as in the prone position. When colon gas partially obscures the gallbladder in these positions, a lateral decubitus position can be used, with the patient placed on his right side. and the film is made in an anterio-posterior projection. Almost invariably with this technique an unobstructed view of the gallbladder is obtained.

"The degree of gallbladder emptying, following a fatty meal as shown by x-ray films, has come under scrutiny of late, and the prevailing opinion is one of doubt concerning its significance. It has been shown that there is considerable variation in the degree of volumetric contraction following a fatty meal in healthy individuals. We believe that the chief advantage of the post-meal film is not to determine the degree of emptying, but rather to spot any tiny calculi which might be obscured by the larger quantity of the opaque material in the initial films of the series.

"In the 'non-filling' of a gallbladder following oral administration of dye, careful consideration must be given to extra-biliary conditions causing this, such as a pyloric or duodenal obstruction; poor absorption from the small intestine in such states as pancreatic dysfunction; vitamin deficiency; mechanical obstruction; and hepatic disease. A gallbladder series in the presence of jaundice is useless and may be harmful. When all extraneous causes for 'non-filling' are ruled out, there is reasonable certainty the 'non-filling' of the gallbladder is on the basis of disease and not technique.

CHRONIC CHOLECYSTITIS	1921 1930	1931 1940	1941 1950	Total
CHRONIC CHOLECYSTITIS with stones	14	77	478	569
without stones	23	46	58	127
GALLBLADDER-INTESTINAL FISTULA cholecystoduodenal	0	0	3	3
cholecystocolic	0	0	1	1
CARCINOMA OF GALLBLADDER	0	1	12	13
PAPILLOMA OF GALLBLADDER	2	2	3	7

Figure 5.

"Approximately 50 per cent of gallstones contain bile salts and for this reason are opaque to some extent. The more apparent can be spotted on routine abdominal films, but the smaller ones will usually be missed if the films are technically poor or if they are not searched for. These same small stones may be invisible in the opacified gallbladder when their density approaches that of the dye.

"The other 50 per cent of gallstones are pure cholesterol and are non-opaque. These are rendered visible only by filling the gallbladder with opaque dye. When there is faint dye concentration, the shadows of the stones become less well rendered.

"The most difficult roentgenographic interpretation occurs when the calculi are tiny in size—the so-called 'millet seed' calculi. There may be hundreds present, though invisible. Several technical tricks will sometimes overcome this. An over-penetrated film with the patient in prone position may show many concentric negative shadows superimposed on the dye; or a film with

the patient in upright position may show the stones layered in the fundus of the gallbladder or floating between layers of bile. The straight line of translucent dots is characteristic and, even with superimposed colon gas, can be identified. If necessary, further information can be obtained with the lateral decubitus position as described previously."

We do not believe in the removal of the gallbladder shown by roentgen examination to concentrate the dye well but showing delayed emptying without stones. The exception is the case with definite clinical evidence of recurring gallbladder colic. In evaluating cases of this type, we have to accept the fact that in the hands of the best roentgenologists there will be a small percentage of the so-called "millet seed" stones that will not be shown. There were several such cases in this series. The patients in these cases usually go from one doctor to another; they have repeated roentgen studies, and not infrequently are diagnosed as neurotics.

When Should the Chronically Diseased Gallbladder be Removed?

Based on the present day mortality as shown in this report (figs. 1-4), it is our belief that all patients with clinical evidence of gallbladder disease, with gallstones or a nonfunctioning gallbladder should be operated upon before there are complications. Frank Lahey observed, "Our medical friends must overcome the complacency with which they permit patients to go through repeated attacks of gallstone colic." William J. Mayo stated,[4] "A gallbladder containing stones is always infected, and when this organ once becomes restless from the irritation of its host, the chance of a complete reconciliation is improbable." While the reported incidence of malignant disease occurring in chronic cholecystitis varies from 50 to 10 per cent, the possibility of a malignant condition alone justifies cholecystectomy. Cholecystectomy was performed 696 times for chronic cholecystitis in this series (fig 2), and it is interesting to note that there were no deaths in the uncomplicated cases.

In Acute Cholecystitis When Should an Exploratory Operation be Performed?

Since Heuer[5] first advocated early operation for acute cholecystitis in 1937, there has been some division of opinion on this subject, due largely, we believe, to a lack of universal understanding of what is meant by acute cholecystitis, and what is meant by early or immediate operation. Our attitude depends on the patient's condition and when he is seen.

In the patient observed twenty-four to seventy-two hours after the onset of the attack, in whom the pain is persisting or increasing, the temperature is remaining elevated or is mounting, the leukocyte count is increasing, and there is definite evidence of spreading peritoneal irritation, especially pronounced in the right upper quadrant, and the gallbladder is palpable, exploration is undertaken at once, or as soon as the fluid and electrolyte balance can be re-established and the patient's general condition warrants it, as these findings constitute a real emergency.

In the case in which the patient is seen during the first few hours of onset of the illness, especially if there is no history of previous attack, we adopt a more conservative attitude, and operation is deferred to give sufficient time for diagnostic study. If we can eliminate the possibility of the acute abdominal tragedies demanding immediate exploration, such as a perforated ulcer, acute appendicitis occurring in the high or undescended cecum, obstruction with strangulation, or acute mesenteric thrombosis, rarely is it hazardous to take enough time for a careful diagnostic study and proper preoperative preparation before surgery is undertaken. Those advocating immediate surgery point to the high incidence of perforation of the gallbladder in early periods of the disease. We believe this has been overemphasized, as shown in 134 cases of acute cholecystitis in this series (fig. 6). There were 7 perforations with walled-off abscesses, but there was no case of early perforation with a generalized bile peritonitis. Heuer[5] reported a similar experience in a study of 89 cases.

In our experience the diagnosis of acute cholecystitis without previous evidence of gallbladder disease is at times difficult, and if cases of this

ACUTE CHOLECYSTITIS	1921 1930	1931 1940	1941 1950	Total
ACUTE CHOLECYSTITIS with stones	2	22	97	121
without stones	0	6	7	13
CHOLECYSTOSTOMY	2	8	3	13
ACUTE PERFORATING CHOLECYSTITIS	0	3	10	13
ASSOCIATED ACUTE PANCREATITIS	0	0	9	9
ACUTE CHOLECYSTITIS following sigmoid resection	0	0	2	2
following herniorrhaphy	0	0	2	2

Figure 6.

type are not given the advantage of sufficient preoperative study, tragic mistakes will be made. As an example, we were called in an emergency consultation to see a patient visiting in Atlanta from a nearby city, and at the time of examination acute cholecystitis was seriously considered. The patient was advised to enter the hospital for study, to include electrocardiogram, roentgenograms and other examinations, but this advice was not taken. He returned to his home town by ambulance, was taken immediately to the operating room of the local hospital, and died as a result of coronary disease while the exploratory operation was in progress.

After a diagnosis is established, operation should be advised. This has always been our practice. Since the clinical manifestations and course of the disease are frequently not an accurate index to the progress of the pathologic process, we have found it unwise to defer operation for an indefinite period, hoping the acute condition would subside. This is particularly true in the older age group. There were 134 cases in which operation was performed for acute cholecystitis (cholecystectomy in 122 and cholecystostomy in 12), with 1 death, a mortality of 0.74 per cent.

The second episode in biliary surgery began with emphasis on cholecystectomy, which removed not only the stones but the diseased gallbladder. At the present time emphasis is on the third episode, that of common duct surgery. This has been well stressed by Lahey and his co-workers. Emphasis is on the necessity of eliminating not only the disease in the gallbladder, but also in eliminating disease in the common and the hepatic ducts. The incidence of exploration of the common duct when cholecystectomy is performed has gradually increased, until now, in some clinics, as many as 40 per cent of common ducts are routinely explored.

While keenly aware of the necessity for the careful evaluation of stone in the common duct as a cause of residual symptoms following operations for gallbladder disease, we believe there is at this time a tendency by some to overemphasize exploration of the common duct. As shown, we have explored 140, or approximately 20 per cent, of common ducts when performing cholecystectomy (fig. 7), and in 46 per cent stones have been removed. As far as we have been able to determine, only 4 of these patients have returned with symptoms of stones in the common duct. In 2 of them the symptoms developed eight and thirteen years after cholecystectomy, respectively.

The criteria for exploration of the common duct have been a dilated common duct, a thickened common duct with contracted gallbladder, and a history of jaundice. The character of bile aspirated from the common duct has not been a reliable indication of stones. Frequently we have aspirated clear, normal-looking bile, only to open the duct and find stones. On the other hand, the presence of muddy bile is invariably indicative of a stone. The presence of clear bile definitely should not deter one from exploration of the duct. In our experience, small stones alone are not sufficient indication for exploration. Especially is this true if the cystic duct is also small. While, in experienced hands and under satisfactory operating conditions, exploration of the duct can be carried out with little added risk, there is some risk, the convalescence is of necessity longer, and in a large series of cases the morbidity is increased. In the hands of the less experienced, operating under less favorable conditions, there is likelihood of an increased mortality.

The differential diagnosis between extrahepatic obstructive jaundice and parenchymatous jaundice is still a major challenge both to the diagnostician and to the surgeon. While there is no desire to decry the various liver function tests, including biopsy of the liver, because they are indispensable, it is our experience that even when they are performed by experienced technicians, they frequently leave a great deal to be desired. A review of the more recent literature reveals that it emphasizes again the necessity of a carefully taken history as the first prerequisite for a differential diagnosis.

SURGERY OF COMMON DUCT	1921 1930	1931 1940	1941 1950	Total
COMMON DUCTS EXPLORED	1	10	135	146
COMMON DUCT STONES	0	7	63	70 ◆
COMMON DUCT STONES, RESIDUAL	0	1	6	7 *
COMMON DUCT STRICTURE inflammatory and postoperative	1	1	9	11
DUODENOTOMY	0	0	11	11
CARCINOMA, COMMON OR HEPATIC DUCTS	0	0	3	3
CARCINOMA, AMPULLA OF VATER	0	0	2	2

◆ 8 patients had no gallbladder stones
* 2 patients had cholecystectomy elsewhere
* 1 patient required 2 explorations of common duct
* 3 patients required duodenotomy
* 1 patient had removal of common duct stone 13 yrs. following cholecystectomy

Figure 7.

JAUNDICE	1921 1930	1931 1940	1941 1950	Total
OBSTRUCTIVE	1	6	46	53
NONOBSTRUCTIVE	2	5	29	36
Total	3	11	75	89

Figure 8.

In this series there were 89 cases of jaundice (fig. 8). Of this number there were 53 cases of obstructive jaundice; 37 were due to stones, 3 to primary carcinoma of the ducts, 2 to papilloma of the ampulla, and 11 to strictures. Except in rare instances, strictures should not give rise to too much difficulty in diagnosis, because of the well known fact that they invariably follow surgery of the gallbladder, at which time injury to the duct occurred.

The so-called "silent stone" occurred in several cases in this series. It should always be considered in a differential diagnosis, in the patient with unexplained fever, with symptoms and roentgen evidence of gallbladder disease. As an example, a 63 year old woman experienced episodes of recurrent fever which ranged from 101 to 104 F. There was no history of pain, nor evidence, clinical or laboratory, of jaundice, but repeated roentgen studies showed a nonfunctioning gallbladder. An exploratory operation was performed, and a chronically diseased gallbladder with stones was removed. The common duct was thickened and tremendously dilated; it contained one large mulberry stone, which was removed. She wore a T tube for two months without recurrence of the febrile attacks and, until now, six months later, she has been entirely well. This is probably the most convincing example of "silent" common duct stone encountered.

Preoperative Preparation

Emphasis has been on fluid and electrolyte balance and blood replacement when needed. Liver function tests and detailed blood chemistry examinations have been made when indicated. The same has been true of the electrocardiogram. The incidence of associated myocardial disease has been a factor in a fairly large percentage of cases, and this group on the whole has proved a satisfactory operative risk, as shown by the mortality rate.

Technic

Anesthesia used was the inhalation type, usually a combination of gas and ether, and, since its advent, pentothal sodium has been used routinely for induction with great satisfaction. Spinal anesthesia has not been used. At the present time the jaundiced patient receives cyclopropane supplemented with curare given with caution.

Since 1930 the right subcostal incision has been routine, except in rare instances. It is preferred because exposure is direct; wound dehiscence occurs less frequently; there are fewer weak scars; and, since in all cases drainage is employed, an additional incision for drainage is obviated. If exploration shows that additional exposure is necessary, this is accomplished by extending the incision to include a left subcostal incision. It is in the acutely inflamed gallbladder that the subcostal incision has special advantages, because, as stated, the approach is direct; and if caution is taken in opening the peritoneum, and the gallbladder is carefully packed off, it is not necessary to expose the general peritoneal cavity at all. In following this procedure the chances of infection are less, and if later there should be evisceration, it is not of such a serious nature. In 3 cases in which it occurred, we found the omentum and transverse colon adhered to the wound, with no evidence of evisceration of the small bowel, and in all 3 cases the patient recovered.

As is true of most surgeons, we prefer to remove the gallbladder beginning at the ampulla, after the duct and artery have been ligated, but it should be stressed that in certain acutely inflamed gallbladders it will be impossible to identify adequately the duct and artery. In this situation, one should not hesitate to remove the gallbladder beginning at the fundus. At times this is the only safe way in which the duct and artery can be safely identified. The principal objection to removing the gallbladder from the fundus downward is excessive bleeding, and in a poor risk or jaundiced patient this procedure can be hazardous. In this situation one would do well to split the gallbladder down the front, including the ampulla, between clamps, and in this way identify carefully the cystic duct and artery. We have done this in a number of cases without difficulty.

There is still some discussion as to the wisdom of cholecystectomy when one is operating for acute suppurative cholecystitis but, as shown in this report, cholecystostomy is rarely done by

us at this time; only 12 cholecystostomies were included in this series. We believe even gangrenous gallbladders had best be removed, provided the surgeon is operating under conditions favorable to satisfactory gallbladder surgery. The convalescence is shorter, and the morbidity is less. It should be emphasized, however, that there is an occasional acute, gangrenous gallbladder, especially in the patient who is a poor risk, which should be drained, even though the second operation is contemplated at the time. Gray and Lafgren,[6] of the Mayo Clinic, reporting a series of 103 cases of cholecystostomy performed for acute cholecystitis, cited that in 30 of these cases secondary operations for various conditions were required. This number constitutes approximately one third of the original group. In spite of this high incidence of required secondary procedures, these authors stressed the desirability of cholecystostomy in certain cases of gangrene, especially as a life-saving measure in the patient who is a poor risk.

The most common anomaly of the duct and artery has been either a short cystic artery, difficult to expose, or a long, abnormally placed right hepatic artery either crossing the cystic duct anteriorly or closely approximating the cystic or right hepatic duct. It is our practice never to clamp either the cystic duct or the artery. Both duct and artery are isolated by blunt dissection and doubly ligated before they are divided. In order to carry out this procedure, one is forced to visualize clearly these structures, and it will be difficult to injure them. The size of the hepatic artery invariably directs attention to itself. There were no injuries to the duct or artery in this series.

Other anomalies were encountered less frequently. There was 1 patient with congenital absence of the gallbladder, who gave a typical history of recurring pain, interpreted as gallbladder colic. Roentgenograms showed no concentration of dye, and on exploration a tremendously enlarged common duct was demonstrated to contain two large stones. We can safely assume that these stones formed primarily in the duct. There were 2 other patients in whom we thought stones probably had formed in the duct. In these patients there developed symptoms of stones in the common duct eight and thirteen years after cholecystectomy, respectively. They were free of symptoms during the intervening years. There were 2 misplaced gallbladders, one behind the posterior edge of the liver, which had been overlooked at a previous exploration done elsewhere, and one on the left side in a patient with situs transversus totalis.

In exploration of the common duct a T tube is used routinely. We never attempt to explore through the base of the cystic duct; neither do we drain through the cystic duct with a straight tube. The one experience we had with the straight tube resulted in a near tragedy. The tube was believed securely anchored to the cystic duct, but in some way the tip slipped through the ampulla, blocking the ampulla. As a result there was a leakage of bile around the tube through the cystic duct, resulting in a bile peritonitis which involved the entire upper portion of the abdomen, resulting in a large subhepatic and left subdiaphragmatic abscess. Two operations were required for drainage of these abscesses. Fortunately the patient made an ultimate recovery, but only after a stormy convalescence. If a stone is impacted in the lower end of the duct and cannot be removed from above, we prefer to perform a duodenotomy and expose the ampulla to assist in removal of the stone. This was necessary 11 times in this series.

The duct is routinely subjected to roentgen examination for residual stones before the T tube is removed. At the present time this examination is made approximately a week after the operation. In this series residual stones were demonstrated in 6 cases (fig. 7). In 2 cases the primary cholecystectomy was performed elsewhere. In 2 cases the stones were small and were dislodged by irrigating the common duct. Irrigation is recommended in cases of small residual stones before additional surgery is performed. In the cases with larger stones, a secondary operation was performed. When there was no evidence of cholangitis, the T tube was removed early, immediately following roentgen examination of the duct, but when there was a dilated common duct or an impacted stone in the ampulla, the T tube was worn for an indefinite period, in one instance as long as eighteen months, without bad results.

In all but 1 of the cases in which operation was performed for strictures (fig. 7), we anastomosed the end of the duct to the duodenum. In this case an end to end anastomosis was carried out. When sufficient duct was available, the end of the duct was flared by making a short incision in the long axis of the duct. This procedure made possible a larger stoma. The cause of recurrent cholangitis following anastomosis of the duct to the intestine is not well understood; some evidence suggests it is not caused by an ascending infection, but probably by a stricture at the point of

anastomosis. This observation has been emphasized by Walters of the Mayo Clinic. It was with this thought in mind that this technic for enlarging the stoma was used. We reoperated on 1 patient with a strictured stoma, a young woman, 30 years of age, in whom a two stage partial pancreatectomy had been performed for carcinoma of the ampulla. At the first operation, the jejunum was anastomosed to the gallbladder. The patient did well for a time, but after three months she began to have recurrent attacks of jaundice, thought to be caused by recurrent cholangitis due to ascending infection. These attacks occurred with increasing frequency, and finally were associated with pain. It should be stated that at the time the pancreas was removed no residual malignant disease could be demonstrated, and it was thought that all of the growth had been removed with biopsy. Thus, we thought we could reasonably exclude the possibility of recurrence and we decided she should be subjected to an exploratory operation for a possible stricture of the stoma. It was found that gallstones had developed, with one large stone in the common duct, with a stricture of the stoma. The gallbladder was removed, along with the stone from the common duct, and the end of the duct was anastomosed to the jejunum. She had a smooth convalescence, and now, twelve months later, has had no further evidence of cholangitis, has regained her weight, and is back at work. This case suggests that the patient who has persistent symptoms of recurrent cholangitis with no evidence of recurrent malignant disease should have the advantage of an exploratory operation. It is gratifying to note that reports from some clinics show the incidence of stricture of the common duct is decreasing.

In the 2 cases of papilloma of the ampulla (fig 4), the lesion proved to be malignant. In both, operation produced good results. In 1, transduodenal resection of the ampulla was carried out, and in the other radical resection of the pancreas after the Whipple technic. One patient lived for approximately three years and died of an associated disease; the other is now well, approximately three years after radical resection of the pancreas. Our experience prompts us to caution against the diagnosis of papilloma of the duct made by frozen section, as this method proved incorrect in both cases reported. In both, the lesions were reported as benign at the time of frozen sections. As is generally conceded, microscopic diagnosis of malignant papilloma is difficult at best and is at times impossible if made by frozen section.

In the case with progressive and completely painless jaundice of the obstructive type which, at the time of exploration, shows a dilated common duct, but with no palpable evidence of pancreatic disease, one should suspect a primary lesion of the ampulla. These were the findings in both of our cases. In 2 of the 3 cases with primary carcinoma of the ducts (fig. 7), the lesion occurred at the junction of the common and cystic ducts, and nothing was attempted. In 1 it occurred in the lower third of the duct and was treated by anastomosing the duct to the duodenum as a palliative procedure. These lesions were all proved malignant by biopsy.

Postoperative Management

The postoperative management has been fairly routine, with emphasis on fluid and electrolyte balance and blood replacement when needed. Rebreathing and antibiotics are now used routinely for the first two to three days, and early ambulation is encouraged but is not insisted upon, except in rare instances. Treatment is directed primarily against the occurrence of complications rather than the use of antibiotics as a corrective measure. This plan is especially desirable in the older age group, particularly in those with chronic pulmonary and myocardial disease. Some of these patients are fair surgical risks as long as they are not allowed to become seriously ill, but the margin of safety is slight and, if they are allowed to become critically ill, the chance of survival is greatly diminished. For this reason, antibiotics are begun immediately postoperatively, even in the cases in which the operation is for chronic cholecystitis. In the cases of acute cholecystitis smears are frequently taken, but we do not wait for laboratory reports to begin antibiotic therapy. With these precautions there has been a minimum of complications. It will be noted that no deaths occurred in this series when surgery was performed for uncomplicated cholecystitis and, we repeat, surgery should be advised before complications develop. Since the use of the subcostal incision has been almost routine, the postoperative period of hospitalization has been gradually reduced until at the present time it averages approximately eight days.

We have noted that dyskinesia of the duct as an explanation for residual symptoms following surgery of the biliary tract has been overempha-

sized. In our experience, such symptoms are more frequently explained ultimately on the basis of associated pathologic change or some psychosomatic factor. This observation is emphasized in the 1949 report from the Mayo Clinic.[7]

Again, we are reminded of the importance of a careful preoperative diagnostic study.

Summary

This report is based upon a personal experience of 850 cases requiring surgery of the biliary tract in which the patients were operated on in private practice over a thirty year period. Experience urges us to advise operation in the chronic cases before complications develop. Emphasis in the acute cases is placed on careful preoperative diagnosis and proper preparation of patients before surgery. In postoperative management, emphasis is on prevention of complications rather than on corrective measures after complications have developed. This management has resulted in a gradual reduction in mortality (fig. 1) from 7.3 per cent in the first ten year period to 0.45 per cent in the last ten year period.

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384 Peachtree Street, N. E.

Management of Massive Hemorrhage from the Upper Part of the Gastrointestinal Tract

Fred E. Manulis, M.D.
PALM BEACH

The occurrence of a massive hemorrhage from the upper part of the gastrointestinal tract creates an emergency which is a challenge both to the security of the patient and to the physician, and remains a potential mortality as long as hemorrhage continues. In no other condition is there a greater need for tempered, experienced, clinical judgment on the part of the physician, as well as for the coordinated facilities of the modern hospital, with adequate nursing, laboratory, and x-ray departments, and most particularly, the services rendered by a well stocked blood bank. In many instances the cooperative efforts of internist, surgeon, endoscopist, roentgenologist and, last but not least, a conscientious house staff, are called into action to conserve life. It is impossible to set up any routines, since clinical pictures vary and are ever changing. Each case presents an individual problem, and constant vigilance is required to achieve desired success.

Etiology

The most common cause of massive hemorrhage of the upper part of the gastrointestinal tract is peptic ulcer. Other causes are ruptured esophageal varices, ulcerating neoplasms, erosive gastritis, diaphragmatic hernia with erosion or ulceration of the herniated mucous membrane, erosion or ulceration of the mucous membrane within a diverticulum, rupture of a sclerotic blood vessel, blood dyscrasias, allergic reactions, aneurysm or abscess ruptured into the gastrointestinal tract.

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Symptoms and Signs

The symptoms and signs of massive hemorrhage from this portion of the gastrointestinal tract are due to (A) the hemorrhage itself, and (B) the underlying disease causing the hemorrhage.

A. Hemorrhage.—Massive bleeding may be manifested by hematemesis and melena, or melena alone. A tarry stool or sudden hematemesis may be the mode of onset. Frequently, the sudden desire to defecate, accompanied by weakness and syncope, and the passage of a tarry stool, usher in the attack. As little as 60 cc. of swallowed blood may produce a tarry stool, but a blood loss of at least 350 cc. is required to disturb the mechanism for the maintenance of blood volume. The initial blood loss calls forth certain compensatory mechanisms to maintain blood volume, producing

peripheral vasoconstriction and an increased pulse rate. The blood pressure remains normal as long as the compensatory mechanism is maintained. As bleeding continues, the body is unable to compensate for the loss in blood volume, and symptoms and signs of shock ensue. These are a lowered blood pressure, rapid thready pulse, pallor, cold and clammy skin, anxiety, restlessness, weakness, dizziness, thirst and dyspnea.

B. UNDERLYING DISEASE.—Signs and symptoms of the underlying cause of the hemorrhage may also be present, and may be exceedingly helpful in establishing a diagnosis. A previous history of pain compatible with the diagnosis of peptic ulcer may be present. When pain exists as a prodromal symptom, it frequently disappears with the onset of hemorrhage. Evidence of peptic ulcer obtained by previous roentgenologic examination is, of course, helpful in localizing the exact site of the lesion. A past history of chronic alcoholism and dietary deficiency, and the finding of jaundice, ascites, spider angiomas, and hepatic or splenic enlargement should suggest the presence of esophageal varices, due to cirrhosis of the liver and portal hypertension. An abdominal mass and evidence of loss of weight would suggest carcinoma of the stomach. A history of vague distress after meals in the upper part of the abdomen, which is worse on lying down and relieved in the upright position in an elderly obese person, suggests diaphragmatic hernia. Evidence of multiple sources of hemorrhage and splenomegaly should arouse the suspicion of a blood dyscrasia as a possible cause of the gastrointestinal hemorrhage.

Management

Early management of this type of hemorrhage involves consideration of the following basic principles:

A. Procurement of the maximum mental and physical rest for the patient.

B. Restoration of normal blood volume.

C. Institution of measures designed to stop bleeding.

D. Initiation of diagnostic studies to establish the etiology of the bleeding.

E. Recognition of cases of continuous bleeding which will not respond to conservative medical measures, and the institution of emergency surgical procedures to stop the bleeding.

F. Recognition of cases, after hemorrhage has subsided and etiology has been established, in which bleeding is apt to occur again, and institution of elective surgical treatment aimed at the elimination of the possible future hemorrhage.

A. PROCUREMENT OF REST.—The procurement of complete mental and physical rest is absolutely essential in the proper management of patients with massive bleeding from the upper part of the gastrointestinal tract. The patient should be placed at absolute bed rest in a hospital, and calmly and confidently assured and reassured that the condition is not serious. A careful selection of competent, intelligent and experienced nursing personnel is most important. The anxiety, restlessness and apprehension, which naturally accompany this condition, must be met with equanimity and a quiet, calm confident approach. No sign of apprehension should ever be displayed by the physician or any others attending the patient.

The judicious use of sedatives is of paramount importance. Knowledge of the patient's particular idiosyncrasies to sedatives is often helpful. In general, one of the soluble derivatives of barbituric acid, such as sodium phenobarbital, which can be given parenterally if necessary, is the sedative of choice. Morphine sulfate should not be used because of its tendency to cause nausea.

B. RESTORATION OF NORMAL BLOOD VOLUME.—Restoration of the blood volume to normal is essential in combating shock due to massive hemorrhage from this area. This is best accomplished by replacing the estimated blood loss by the transfusion of whole blood. If blood is not immediately available, an intravenous infusion of blood plasma is second in preference. If neither whole blood nor blood plasma is available, a 5 per cent solution of glucose in normal saline should be given intravenously and whole blood or plasma substituted as soon as they become available.

In order to evaluate the amount of blood loss and evidence of bleeding activity, certain measurements should be instituted. The pulse rate and blood pressure should be taken and recorded every thirty minutes until one is convinced that the hemorrhage has been controlled. A complete blood count and hematocrit reading should be made on admission to the hospital, and thereafter a red cell count, hemoglobin and hematocrit determination should be made once daily. If the hematocrit reading is normal and the blood volume is obviously reduced, one will be unable to determine the magnitude of the hemorrhage until the dilution factor has become manifest. As soon as the diluting influence takes place, the erythrocyte count and the hemoglobin percentage decrease, thus

serving as a fair index of the amount of blood lost. The extent of the elevation of the blood urea nitrogen may be used as a gauge of the severity of the bleeding, according to some authors. Hyperazotemia may be due to shock with diminished cardiac output and diminished renal blood flow, or to absorption of the products of digestion of blood protein, or to a combination of both factors. Clausen,[1] by introducing 500 cc. of ox bile into the human stomach, doubled the normal blood urea nitrogen concentration in eight hours. Clinically, there is usually noted a maximum rise in blood urea nitrogen twenty-four to forty-eight hours after a massive hemorrhage, with a return to normal at the end of seventy-two hours after active bleeding has ceased.

There is some difference of opinion as to the use of blood transfusion in the treatment of massive hemorrhage from this portion of the gastrointestinal tract. Those who object to the use of transfusion argue that further bleeding may be caused by suddenly elevating the blood pressure. This idea has been largely discredited by the publications of Browne and McHardy[2] and Kirsner and Palmer,[3] who found no evidence of prolonged bleeding nor elevation of blood pressure if the blood is given slowly. It should be emphasized that blood be administered slowly, at the rate of 4 cc. per minute, so that a 500 cc. transfusion requires approximately two hours for complete absorption. Given over a two hour period, 500 cc. of blood does not elevate the blood pressure significantly, unless the patient is in shock. Under these conditions the blood pressure is increased gradually over the two hour period and rarely returns to the prehemorrhage level with one transfusion.

Also to be considered with the maintenance of normal blood volume is the establishment of normal water and electrolyte balance. Since shock is frequently accompanied by oliguria and anuria, it is essential to measure the urinary output daily. In such instances a patient should receive adequate parenteral fluids to maintain a renal output of at least 800 cc. each day. The total daily intake of fluid should approximate 2,000 to 2,500 cc., depending upon the dehydration, azotemia, renal output, presence or absence of edema, and cardiac status of the patient. The water and electrolyte requirements may be regulated by frequent determinations of the blood chlorides, blood urea nitrogen, and carbon dioxide combining power of the plasma.

C. Institution of Measures Designed to Stop Bleeding.—

1. Feeding: The question of whether or not to feed patients with active hemorrhage from the upper part of the gastrointestinal tract has long been a controversial subject. Throughout recent years, more and more authors have favored the principle of early and frequent feeding, which was pioneered in 1927 by Andresen.[4] This was a radical departure from the then popular principle of allowing a preliminary starvation period of twenty-four to seventy-two hours. Andresen's rationale that frequent feedings reduce the amount of unbuffered acid gastric juice and decrease gastric motility has now been well established by animal and human experiments. Andresen's diet consists of four ounces of a gelatin, a lactose-orange juice-water mixture, given every one and a half hours for two days, and then alternated with a cereal gruel, a milk-cream-lactose mixture, from the third to the ninth day.

Since then, many modified diets have been introduced, reaching the other extreme by Meulengracht,[5] who first recommended the immediate use of a high caloric, puree diet, along with alkalis, antispasmodics and iron in the treatment of hemorrhage from ulcer. Included in Meulengracht's list of foods were such items as meat balls, fish balls and broiled lamb chops. The patients were permitted as much food as they desired. Most gastroenterologists today prefer the Andresen diet, or modification thereof, to the Meulengracht regimen, or the principle of early starvation, believing that the former is more likely to promote acid neutralization and gastric motor rest and relaxation than any other program of feeding. It goes without saying that if the patient is in deep shock, or if there is persistent nausea and vomiting, oral feedings must be withheld until the patient is able to retain them.

2. Antacids: If hemorrhage is due to peptic ulcer, the presence of highly acid gastric juice will tend to perpetuate or even extend the confines of the ulcer and may even interfere with the fibrin clot which usually forms at the bleeding point. For this reason the addition of colloidal aluminum hydroxide to the frequent milk-cream feedings will enhance the neutralization of the acid gastric juice. The only untoward effect noted from the use of aluminum hydroxide is constipation. Some authors have introduced aluminum hydroxide in the form of a continuous intragastric drip as the best means of neutralizing acid gastric juice and

preventing fibrin clot digestion, but this procedure has not attained widespread recognition, since intubation may provoke further bleeding and is definitely contraindicated if esophageal varices are suspected.

3. Drugs: Drugs which block parasympathetic impulses, such as atropine and belladonna, have long had a place in the management of hemorrhage from ulcer. More recently methantheline bromide (Banthine), which theoretically performs a medical vagotomy, has been replacing atropine and its derivatives. By its anticholinergic action it reduces hyperacidity and controls hypermotility.

4. Vitamins: Although a deficiency of vitamin C has never been proved to be the cause of peptic ulcer, secondary vitamin deficiency may occur due to inadequacies in diet, and especially during hemorrhage. It is good practice to give 100 mg. of vitamin C daily, parenterally during active bleeding and orally later, until an adequate diet may be taken.

A prothrombin time should be determined on every patient with massive hemorrhage on admission to the hospital. A decided posthemorrhagic prothrombin deficiency may exist in the absence of hepatic disease, although it is more frequently noted with disease of the liver, or of the liver and spleen. The intramuscular injection of 2 mg. of vitamin K every four to eight hours promptly restores the prothrombin time to normal in most cases of posthemorrhagic prothrombin deficiency. If the level does not return to normal, one must suspect severe hepatic damage.

5. Tamponade: Another recent addition to the medical armamentarium in stopping hemorrhage, arising especially from the cardioesophageal regions, is pneumatic tamponade, with or without the addition of topical thrombin. Rowntree, Zimmerman, Todd and Ajac[6] reported modifying a Miller-Abbott tube by occluding the upper six holes and attaching an elongated balloon to the lower three holes. When the balloon was inflated, it produced a satisfactory tamponade along the length of the lower end of the esophagus, with the distal pole of the bag at the cardia. Others have passed the tube into the stomach, inflated the balloon with air, and then pulled it back against the cardia, securing the external portion of the tube against the nostril to prevent slipping.

Since, at necropsy, most ruptured varices are found at, or just cephalad to, the cardioesophageal ring, this procedure will probably successfully tamponade most bleeding varicosities. In those cases in which the hemorrhage is occurring proximal to the area of contact with the bag, the occlusion of the veins supplying the bleeder may well be sufficient to produce hemostasis. After the balloon is in place and distended adequately to secure tamponade, the patient may be given by mouth at thirty minute intervals 5 cc. of a 1:10 buffered solution of topical thrombin for a total of four doses. This solution seeps down around the tamponade and provides additional hemostasis in areas where oozing continues.

D. Diagnostic Studies to Establish Etiology of Hemorrhage.—If active bleeding shows signs of being controlled by conservative medical methods, there is no particular hurry about establishing the etiology. When the indications are present that bleeding has definitely terminated, however, careful roentgenologic studies should be made. In many instances the bleeding source will become obvious. In the absence of definite roentgenologic findings, or when supplemental evidence regarding the nature of the bleeding lesion is desirable, endoscopic examination should be performed. Gastroscopic examination is the only positive way to demonstrate an active gastritis that is responsible for hemorrhage. Esophagoscopy is of use primarily in obtaining biopsy material from a suspected esophageal growth. It should not be used to visualize varices, which are almost always readily shown by proper roentgenologic studies of the lower portion of the esophagus. The introduction recently, by Benedict,[7] of an operating gastroscope, making it possible to obtain specimens for biopsy from suspicious gastric lesions, has added considerably to the value and scope of the gastroscopic study.

Laboratory tests are of much less diagnostic importance than the measures discussed, in determining the source or nature of gastrointestinal bleeding.

The bromsulfalein test may be of inestimable value in helping to screen patients with hepatic cirrhosis from those without disease of the liver. In this way, patients with ruptured esophageal varices may be separated from those bleeding from another site. Zamcheck, Chalmers, White and Davidson,[8] in a study of 61 cases of massive hemorrhage, performed routine bromsulfalein tests, using 5 mg. of dye per kilogram of body weight. They concluded that a continued high retention of the dye occurred in patients with proved cirrhosis of the liver, and a normal retention or one slightly elevated, falling promptly to normal, was

present in patients with no known hepatic disease. Obviously, this test is not infallible, since severe shock, advanced age, and possibly fever causes, but not always, an increase in retention of bromsulfalein dye. It should also be remembered that varices caused by extrahepatic portal obstruction (Banti's syndrome) cannot be distinguished by this test in the absence of hepatic disease. Also to be considered is the fact that bleeding in patients with cirrhosis of the liver can be caused by other lesions than varices.

Gastric analysis should never be made until active bleeding has definitely stopped, and should always be preceded by a roentgen study. The finding of histamine achlorhydria in the presence of a demonstrated gastric lesion is of value because it implies carcinoma as the underlying cause. Otherwise, a gastric analysis is of little value and is a needless procedure. It should never be done if esophageal varices are at all suspected.

When bleeding is due to a blood dyscrasia, such as thrombocytopenia, proper blood studies are obviously diagnostic.

In the presence of continuous bleeding, which will necessitate emergency surgery, roentgen examination should be made in an attempt to locate the lesion. A patient should not be examined while in clinical shock, but, as soon as the blood volume can be replaced with adequate transfusions, the roentgen examination should be performed, in the presence of continued bleeding. The examination should be performed without any palpation, with the patient in the horizontal position; peristalsis and gravity should be utilized, by turning the patient from side to side, as a means of distributing the barium over the inner surfaces of the esophagus, stomach and duodenum. Blood clots that lie in the stomach handicap the proper interpretation of the roentgenograms, although they do not prevent the diagnosis of varices of the esophagus, diaphragmatic herniation, large ulcers of the stomach, or ulcers of the duodenum.

Examination of the bleeding patient should not be stopped at the duodenal cap. Tumors of the duodenum are rarer than those of the stomach, but they do occur, and unless carefully looked for, are frequently missed. Demonstration of a possible source of bleeding should not prevent one from continuing the examination to its completion, unless the patient is in a precarious condition, since occasionally another bleeding lesion may be found. Any patient in whom early examination has not demonstrated the cause of the hemorrhage should be re-examined at a later date, if the hemorrhage has subsided, when palpation is possible and the patient is permitted to stand. Some bleeding lesions are demonstrated during the early examination, and others at a later, more convenient and more thorough one. In spite of every diagnostic maneuver known to the roentgenologist, the source of bleeding in a certain number of cases will remain obscure.

E. Emergency Surgery.—In any given series of cases with massive hemorrhage from the upper part of the gastrointestinal tract, the bleeding, under medical management, will cease spontaneously in the majority of instances, and in a minority will prove fatal if emergency surgical intervention is not instituted. The selection of those patients whose hemorrhage will continue unabated without surgery and prove fatal from those whose hemorrhage will be controlled by conservative medical management alone is often extremely difficult. Each patient must be carefully individualized, and observed closely, while under conservative medical management for twenty-four to forty-eight hours. To operate routinely in all cases of severe bleeding would result in a mortality far greater than with medical treatment alone.

Since peptic ulcer is by far the most common cause of massive bleeding, a more detailed discussion of its surgical management is in order. In patients with fatal hemorrhages, the location of the ulcer, if duodenal, is on the posterior duodenal wall and, if gastric, on the lesser curvature of the stomach. The blood vessels causing the fatal hemorrhage are the pancreaticoduodenal and the right and left gastric arteries, or their major branches. Local ligation of the vessels giving rise to hemorrhage has not consistently and permanently controlled hemorrhage. Local excision of the bleeding ulcer and gastric resection, including removal of the ulcer, have given the best results.

Massive, continuous, persistent hemorrhage from peptic ulcer, in spite of a strict medical program and adequate blood transfusions, is an indication for surgical intervention. The recurrence of severe hemorrhage with evidence of shock, several days after recovery from a massive hemorrhage, is another indication for emergency surgery. The age of the patient is an important factor. Fatal hemorrhages are likelier in patients over 50 years of age because of a higher incidence of arteriosclerosis and cardiorenal complications.

Fatal hemorrhages are less frequent among women than among men, and the statistical chance of recovery with medical management in either sex is better after multiple hemorrhages than with the initial hemorrhage. The question of when to operate in the case of continuous massive bleeding has been discussed by many authors. Finsterer,[9] Gordon-Taylor[10] and Heuer,[11] advocated early operation, within twenty-four to forty-eight hours, to save the most lives, since the mortality rate rises precipitously after this period.

F. ELECTIVE SURGERY.—After the initial hemorrhage has subsided and diagnostic studies have been initiated to establish the underlying condition responsible for the hemorrhage, the finding of certain specific lesions may be an indication for elective surgery. The presence of a neoplasm of the esophagus, stomach, or upper part of the small intestine would be an indication for surgery. The finding of a gastric ulcer, in some clinics, would be an indication for routine subtotal gastric resection, and in others, would be an indication for resection if the ulcer failed to heal after an adequate trial on strict medical management. Bleeding from ruptured esophageal varices due to portal hypertension from cirrhosis of the liver might be an indication for one of the new shunting operations between the portal and systemic venous systems recently pioneered by Blakemore[12] and other vascular surgeons.

Patients who recover from massive hemorrhage due to peptic ulcer present an important problem. The majority of those patients who have had two or more hemorrhages are likely to suffer from further episodes of bleeding. Thus, if the patient, particularly in the older age group, has had two or more massive hemorrhages from peptic ulcer, elective surgery should be contemplated, provided there are no definite contraindications such as cardiovascular or renal complications. The operation of choice in cases of this type is subtotal gastrectomy.

Summary

The proper management of patients with massive hemorrhage from the upper part of the gastrointestinal tract requires the cooperative efforts of internist, surgeon, endoscopist and roentgenologist, in a hospital with conscientious house staff, adequate nursing care, and a well stocked blood bank.

Individualization of each patient is essential.

Adequate blood replacement and maintenance of normal blood volume and electrolyte balance are of paramount importance.

Etiology should be established shortly after bleeding stops in those cases in which bleeding subsides spontaneously, and as early as possible in those cases in which the lesion appears to bleed continuously.

In about 85 per cent of all cases there is response to conservative medical management, and the hemorrhage subsides spontaneously. After the etiology has been established, in a small percentage of these cases there will be indications for elective surgery to prevent further bleeding.

In the remaining 15 per cent the continuous bleeding requires surgical intervention. In these cases, as much diagnostic information as is practical and possible should be obtained early, and surgery should be instituted within twenty-four to forty-eight hours after the onset, since the mortality rate rises precipitously after this period.

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224 Sunrise Avenue.

A New Concept of Baby Feeding

Walter W. Sackett, Jr., M.D.
Miami

There is presented herein a new concept of baby feeding based on a six hour feeding interval from birth. This regimen at any selected date easily evolves into a three meal a day schedule. This is in contrast to the generally accepted standard of a four hour interval and to the more recent ideas of a demand schedule. This concept further involves the earlier introduction of foods other than milk.

In routine office practice one is astounded by the number of hungry babies, the colicky babies, the multiplicity of feeding problems and the many insecure mothers who besiege the general practitioner. For a long time I have ruminated upon the part which present popular feeding theories play in these problems and, through a series of events to be related shortly, I offer my experiences and results with a six hour feeding schedule as introduced at birth, as an answer to these problems.

Probably no field of medicine has been subjected to so much unscientific speculation as has the art of baby feeding. Despite the fact that medicine today is more apt to advise the adult that he is eating too much and too often, the trend in the feeding of infants is to feed them just as often as they manifest hunger, and this manifestation usually is agreed upon as being merely the act of crying. Contrary to general trends, it is my opinion that normal infants do much better on scheduled, further spaced feedings and, what is more, the parents also thrive on this schedule.

Until 1940, it was the common practice to teach, in pediatrics, that babies should have nothing more than milk and orange juice until the age of five months. In the early nineteen-forties there emanated from pediatric centers in Boston and New Orleans the thought that infants could be put on a three meal schedule at three to four months of age. This naturally involved the introduction of foods other than milk at a much earlier period than three to four months, so that my attempts to test this theory led to starting babies on foods other than milk as early as four to six weeks. In 1948 a newborn infant was encountered with a complete duodenal obstruction. This infant survived such nourishment as was limited to parenteral administration for a period of three weeks, during which time diagnostic data were being collected. He subsequently tolerated a gastrojejunostomy as few adults could. The rapid and striking manner in which this newborn infant reached normalcy, as was determined by standards set up by his twin, made one stop and cogitate as to the actual importance of feedings in the neonatal period. It was these events, plus the casual remark of a nurse in regard to the routine 2 a.m. feeding, which convinced me that babies might do just as well on infrequent feedings as on frequent feedings. This remark was, "Why start them on something you plan to stop so soon?"

A review of the literature reveals a paucity of data, particularly scientific, as to the frequency of infant feedings. The early Egyptians believed that breast milk should be the sole source of nourishment in the neonatal period with nursing to be continued into the third year of life. Hippocrates did not mention the frequency of infant feeding in his writings. Soranus, who antedated Aretaeus and Galen, thought that for the first two days the newborn infant should not be nursed at all. Aëtius, who followed Aristotle, was the only advocate of a three meal schedule in the long history of medicine. He advised nursing infants only three times daily for six months, this diet to be varied with eggs, honey and wine, with weaning to take place at twenty months.

Dewees, one of the early American professors of midwifery, made little mention of the frequency or regularity of feeding, but pointed to the danger of feeding in quantities too great. More recently Grulee, in speaking of "neurotic infants," cautioned against irregular and too frequent nursing, whether this produces colic or not. He mentioned two schools of thought as to the interval of feeding, namely, one school leaning to the two hour interval and the other to the four hour interval. Hill wrote of feeding babies four to five months of age who will not take large amounts at one time

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and advocated feeding them to advantage on a two and one-half hour schedule. Further, he approved of feeding the baby all he will take irrespective of calories. For habitual loss of appetite he mentioned a number of causes, among them "too frequent feedings, I mean intervals of less than three hours." In writing of children 1 to 4 years old, he stated that "a child frequently does not like solid food and as each new article of food is begun he spits it up."

With these meager and still conflicting theories on feeding of infants in mind, I proceeded with my mental gyrations as to the frequency of infant feeding with the idea of trying out my theories on certain selected cases. One of my patients apparently fell in step with my musings and requested that her baby (the fourth) be permitted to try this new schedule; and so when this baby A was born, he was put on a three meal a day schedule from birth; at the time of leaving the hospital at the age of 8 days, he was taking 6 ounces at each feeding. Baby B with a birth weight of 5½ pounds was put on a similar schedule. This baby, who was subjected to unusual circumstances not of a physical nature, was observed in the hospital for several months and will be the subject of discussion in a later paragraph. Baby C had as his parents apartment dwellers and was the initiating factor in the introduction of a fourth feeding at midnight. These babies do as all babies will, awake and cry during the night, and for the benefit of neighbors and parents this midnight feeding was instituted.

With a total of approximately 32 private babies and 18 institutional babies on this regimen, these constituting a source of trial and error, the following schedule has evolved:

At birth—Breast and/or bottle is given at 6 a.m.; 12 noon; 6 p.m.; and 12 midnight.

At three to four days—Cereal is added to the 6 a.m. and 6 p.m. feedings.

At ten days—Strained vegetables are added at noon. Peas, beans and carrots are suggested for starting.

At seventeen days—Strained fruits are added at the 6 p.m. feeding. Cereal is dropped or gradually decreased in quantity at this feeding.

At weekly intervals—Add strained meats, orange juice (usually diluted), custards, soups, mashed ripe banana and hard boiled egg yolk.

Some form of cod liver oil may be worked in at any convenient period. The midnight feeding is dropped at any time convenient to the mother, the earlier the better. Many mothers are doing this of their own accord, thus placing their babies on a three meal a day regimen often as early as three weeks.

Studies of the individual babies subjected to this regimen, made with the limited facilities available to the average general practitioner, reveal an astounding approach to the average baby. Charts too cumbersome for publication reveal a surprising paralleling of the weight curves of the observed infants to those of the average infant.

Table 1 illustrates weights recorded on routine visits. Inasmuch as all babies did not come in at the specified times, about one third of the weights were arrived at by reading them from graphs kept on all babies. There are 6 babies whose records are not included in this chart because these babies did not adhere to the six hour schedule, though I know of no instance in which the early introduction of foods was not followed closely. There are also another 5 babies who have not been on the schedule long enough to give weight readings for the first month.

There is not represented here a group of approximately 18 institutional babies concerning whom only generalized conclusions can be drawn at this time. The nursing staff is well satisfied with weight gains exhibited so far. Because these infants are of a mixed age group, and come and go at the direction of welfare authorities, it will be some time before accurate conclusions can be drawn from this group. It might be noted here that in no instance did these infants experience the slightest difficulty in conforming to the six hour interval between feedings.

Unfortunately, because of the short hospital stay of the modern obstetric patient, there are no figures to illustrate faithfully the reluctance of these babies to meet the daily weight gain usually observed in the first weeks of life. In my opinion, this discrepancy can be offset by slight alterations in feeding during these early days of life; some of these alterations have already been introduced and are represented in the schedule set forth here.

A limited number of laboratory studies show little or no variations from the norm. For instance, on Baby B on the eighteenth day of life laboratory reports were as follows: red blood cell count, 5,250,000; hemoglobin estimation, 106 per cent (17 Gm. Sahli); color index 1.0; white blood cell count, 16,200; differential count, eosinophils 1, stab forms 4, segmented forms 21, lymphocytes 82 and monocytes 2. There was moderate macrocytosis with anisocytosis. Urinalysis showed: col-

Table 1. — Weights of Babies at Various Age Levels

	At Birth		1 month		3 months		5 months		9 months		12 months		14 months		24 months	
Normal	7 lb.	4 oz.	8 lb.	12 oz.	11 lb.	12 oz.	14 lb.	8 oz	18 lb.	12 oz.	22 lb.	0 oz.	23 lb.	0 oz.	28 lb.	0 oz
Baby A	9	10½	10	0	14	2	18	4	19	12	21	8	24	0		
B*	5	6	6	2	10	0	12	0	15	0	17	3				
C	8	4	9	9	13	0	16	3	21	7	23	0				
D	7	10	8	12	10	0	13	2								
E	7	8	8	12	13	8			(Unable to contact)							
F	8	1	9	3	11	12	16	9								
G	7	3½	8	10	12	10	16	6								
H	7	11	9	2½	12	5	15	9								
I	7	1	8	6					(Left town)							
J	6	2½	7	10	12	12	16	3								
K	8	5	9	7					(Unable to contact)							
L	7	5	9	2					(Left town)							
M	7	9	8	7	12	0										
N	6	8	7	5	9	7½			(Anemia problem)							
O	5	7	6	2	10	6										
P	10	5	11	10	15	4										
Q	7	1	8	10	13	3										
R	6	0	7	0	8	12										
S	8	8	9	6												
T	6	9	8	0	14	0										
U	8	1	8	11	11	3										
V	5	6	7	2												
W	7	10	9	0												
X	8	4	8	12												
Y	6	1	8	0												
Z	6	9	7	10												
AA	7	7½	8	5												
BB	5	7	6	4												

*This infant was the only one in whom weight gains could be observed daily during the first two months of life. The maximum weight loss in the neontatal period was 2 ounces. It was eleven days before this infant surpassed his birth weight while in the first twenty-six days of life he gained a total of 10 ounces.

or, yellow; specific gravity, quantity not sufficient; albumen, negative; sugar, negative; diacetic acid, negative; white blood cells, 2 to 6; red blood cells, rare; casts, none; and bacteria, a few cocci.

Of interest might be the story of infant C. At three months this infant had a routine examination of the blood showing a red blood cell count of 2,750,000 with a hemoglobin estimation of 62 per cent. Because it was done for its statistical value, this count went unnoticed, and hence untreated, until the baby came in for a routine visit at six months of age. At this time, without any treatment whatsoever, the red blood cell count had risen to 3,750,000 and the hemoglobin estimation to 78 per cent. In contrast to this record, an older sibling while on hematinic therapy manifested a lesser rise in hemoglobin from 68 per cent to 74 per cent.

The advantages and disadvantages of such a revolutionary schedule, as related by the parents and hospital nurses and as observed by me, are as follows:

Advantages

1. These babies are much more contented; they are not taught to cry for a feeding at each awakening period. They quickly learn to lie in their cribs and amuse themselves.
2. They learn easily to eat from a spoon at an early age, a feat often difficult for a five to six months old child.
3. They accept new foods extremely well, because, in my opinion, they are introduced to them before they acquire likes and dislikes and because of a personal theory that any person will eat anything if he is hungry enough.
4. The practice of infrequent feedings is good insurance for good eating at a later date in life. I so frequently see children who have been started on a demand schedule and who later present feeding problems.
5. These babies have less frequent and better formed stools and are less given to bowel upsets.
6. These babies quickly learn to take large amounts of food without too much urging, sufficient to carry them from one feeding to the next.
7. The parents of such babies are happier parents because they realize that their babies are not fragile creatures and that feeding them both old and new foods is easier.
8. To a mother this offers the advantages of longer periods of rest and freedom between feedings.

9. With the early addition of foods, the necessity of vitamins and mineral supplements becomes optional and more often than not, unnecessary.

Disadvantages

1. It has been observed that initial weight gains according to standards, which in my estimation are empiric, are less rapid than with those babies on a more frequent feeding schedule. These weight discrepancies are later erased in the two to four months period.
2. The problem of crying at night in the first few weeks of life has been satisfactorily met by the addition of the midnight feeding and the 6 p.m. cereal feeding.
3. It takes more time to condition the mother to the acceptance of such a routine than it does for the acceptance of one of the older ideas.

Trials so far involve only cooperative and selected mothers. It is possible that observations may not be so favorable once the regimen is tried routinely on large groups of infants regardless of the temperament of the mothers.

Summary

In summary, it would seem from the foregoing that in presenting this radically new idea of baby feeding I have failed to make any contribution to the apparently long-established thought on this subject, but rather have added only fuel for further controversy and confusion. Such is not the intention. I am merely attempting to demonstrate that babies on infrequent feeding schedules do not suffer from such variations from the older regimens. It is my hope that I will eventually be able to demonstrate that babies do equally as well physically regardless of their feeding regimen. In doing so, it is my further hope that I will have contributed some little bit to the endeavor of creating more emotionally stable mothers and a lesser number of feeding problems in growing children without jeopardizing the health of the baby.

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2500 Coral Way.

Discussion

DR. EDGAR E. HITCHCOCK, Orlando: This paper has been most interesting, and I am more than delighted to hear this type of paper coming from a general practitioner. I wish to compliment Dr. Sackett on this presentation. He is dealing with a problem that is open to considerable criticism from pediatrician, allergist and obstetrician alike.

As I listened to this paper, several points came to mind that you as general practitioners may question, and I will endeavor to clarify these points.

As you have heard, Dr. Sackett is not following a self demand schedule of feeding the baby when he is hungry, but advocates a six hour schedule. No doubt, those of you who practice obstetrics wonder about the mother's breast on this schedule. Will she produce sufficient milk if the breasts are not emptied more often than six hours, since frequent emptying of the breast is the best stimulant to milk production? I think that I can answer this question in the affirmative by saying that most babies on self demand schedules who go from three to six hours on the breast usually do get sufficient breast milk for gratification, and the mother's breasts are no more painful as a rule.

The next question that is probably uppermost in your mind is, Can the newborn baby tolerate and actually digest food other than milk during the first months of life? As noted, Dr. Sackett introduced cereals at four to seven days, strained vegetables at one to two weeks and fruits at two to three weeks. Regarding the digestion of foods in the newborn Dr. Clement Smith, well known physiologist, stated that the normal newborn infant has a physical capacity for food which is unlikely to be exceeded by any ordinary dietary program. The enzymes present in the infant's system have not been found inadequate to deal with any type of food except complex carbohydrates. The infant has the greatest ability to assimilate proteins such as milk and meats. The reverse is true of fats, although the difficulty does not appear to be due to a lack of fat-splitting enzymes. Simple carbohydrates such as milk and cane sugar (disaccharides) and dextrose (monosaccharides) are easily assimilated by the infant at birth. Experience has shown that formulas based on high protein, low fat content with calories derived mainly from protein and carbohydrates are in all probability the most nourishing for the newborn infant.

Probably there will be some criticism from the allergist on the early introduction of solid foods. No doubt there is danger of sensitization to certain foods if introduced too early; yet there is also danger of overloading the hungry baby with too much milk. It is sometimes a problem whether we should feed rich milk formulas in abundance or take a chance on starting solids at an early date. Personally, I think there is less danger of sensitization by starting small amounts of cereal or other solids as the baby's appetite increases.

There are many advantages to a schedule like the one Dr. Sackett has presented. I agree with him that both baby and mother will certainly get more rest. As he has stated, the babies in his series did not gain too vigorously at first, but they soon made up for lost time. I believe Dr. Sackett's routine will work out in the normal infant, but think it will take a much larger series of cases to determine whether this routine should be tried generally.

I do not believe this routine will work out too well with the hypertonic infant who demands feeding every two to three hours, the allergic infant in whom one sensitivity after another develops, or the small infant weighing less than 6 pounds who has too small a feeding capacity to endure the six hour interval of feeding. This group of infants, however, will present a problem regardless of type of feeding.

As a constructive criticism of this paper, I would recommend that cereal not be offered at a specified age of four to seven days or strained vegetables at one to two weeks, but would rather let the infant decide and demand when he needs more food, other than breast or bottle, whether it be at two or four weeks. This plan might lessen the possibility of intestinal upset, regurgitation and early sensitization to foods.

Some Observations on the Interrelationships of Allergy and Diseases of the Chest

Clarence Bernstein, M.D.
and
Solomon D. Klotz, M.D.
Orlando

Any wide discussion of allergy and diseases of the chest would assume encyclopedic proportions if it were not arbitrarily circumscribed and delimited. The ordinary typical clinical entities in each of these fields are fairly well understood, and by and large offer no unusual problems in diagnosis. These are seen by general practitioners, or via the latter by specialists in either field. Thus, the victims of these maladies reach proper hands for definitive management. The old rule-of-thumb, however, that "all is not asthma that wheezes," is occasionally overlooked, and it is well to be reminded that thorough study and care may be necessary before proper diagnosis and therapeusis can be achieved in these patients. Even the cursory view of the interrelationship of allergy and pulmonary diseases brings up one or two phases of this problem which may be worthy of consideration.

First we shall discuss the cold-and-cough susceptible child. This is the four-to-eight-year-old youngster who as a result of repeated protracted illnesses enters the office clinging to his mother. He is fidgety, pallid, wet-nosed, and quick; he rubs his nose with his thumb, forefinger, or palm, sucks back air and mucus into his posterior nasopharynx with a guttural, muted cluck, swallows visibly, and may give vent to a short, or even productive, cough. He has pale days and pink, complexion-wise, and unexplained fever. He is described as perspiring easily and "freely" particularly during sleep. Overheating from exertion or "playing too wildly," mother avers, "gives him all these colds," even though the brothers and sisters seem rarely to catch them by contact. Overeating, on the other hand, is never complained of; all patients of this type have finicky appetites. Laughing hard, running, or choking on a peanut, is enough to provoke paroxysms of coughing, wheezing, or the frank asthmatic seizure. The cold season, whether North or South, is his nemesis, and frequently Florida residence has been sought in the vain hope that "there he should do better." If he tends to run fever he may even have been sent South because of a suspected rheumatic state. Relaxed, pronated ankles, and myopic lenses, commonly round out the picture.

This clinical constellation is only too well known. Certain points, however, may be worth making even though they elicit heated disagreement. Children who present this picture are brought to doctors because they are sick, or have dis-ease in its primary meaning. The psychosomatic factors that have crept in are in the vast majority of instances after rather than before the fact. These youngsters have been mothered too much, and usually doctored too much, or at least more than was necessary had the true nature of their complaints been understood in the first place. The tonsillectomies and adenoidectomies, and the many medical consultations held when these operations failed of the desired result, have not contributed to the well adjusted personality. The unhelped child certainly did not make for a less anxious mother.

Assuming that food or inhalant allergy lies at the basis of the disorder, what is the mechanism in the clinical picture just outlined? The explanation is almost on a mechanical basis. Mucous membranes reacting allergically make mucus, and also become engorged and swell. If the organ lined by these membranes is hollow and possesses a muscular wall, the organ itself may go into spasm. This sequence of events is responsible for clinical allergic phenomena. The allergy in itself, or the reaction of the individual to physical or emotional changes, may each alone produce the symptoms. Concerning the specific response to known allergens there is no debate save when the question of "conditioned reflex" enters in. As regards the nonallergic phases, the symptomatology is almost pure mechanics.

Read in part at the Sixth Annual Meeting of the Southeastern Allergy Association, St. Petersburg, Jan. 20, 1951.

A certain amount of mucus is constantly present in the lumen of the bronchial radicles. An indraft of cold air, or sudden fluctuation of temperature, changes the relation of the bronchial wall to this mucus. Likewise, an emotional reaction, a hard laugh, or a sudden cough, may dislodge a previously quiet bit of mucus, or cause constriction of the bronchus onto the mucoid mass. Then follows cough, wheezing, or asthma, depending on the severity of the stimulus or of the reflex action. The effects are additive in that the mucus is present in a larger amount than normal because of the allergy, and the allergy not infrequently heightens the over-all physiologic irritability of the affected person. Further, if one can assume that all allergens are discovered and excluded, a much too optimistic assumption usually, the physiologic habit will remain for indeterminate periods of time after successful management of the allergy has been instituted. This serves simply to make the clinical picture even more complicated. Now, however, should a psychotherapist come along and resolve the environmental, and emotional, irritating factors to the point where the physiologic responses are reduced, the clinical improvement will then be said to justify the diagnosis of a psychogenic etiology. Only careful study and controlled observations can untangle the complicated skein of such a clinical history.

Going a step beyond this clinical entity to the chronic unexplained fever requires but a slight extension of the pathogenesis recounted. These infants and children who carry mucus around in their bronchial tree, at almost any given time have small segments of the lung obstructed by inspissated mucus with or without mild grades of bronchostenosis or spasm. If the plugs are not promptly dislodged, small areas of atelectasis develop, and when drainage is too long prevented, varying degrees of infection or autolysis with repair, or both, take place. This process is quite enough to cause fever, especially of low grade, and on occasion it may set up a frank pneumonia, as described by Friedman and his associates[1] and several others. The Balyeat group[2] reported the wedge-shaped shadow which they commonly find in these cases. It would appear that nature uses this mechanism to stop an asthmatic seizure, as so frequently a pneumonic febrile episode terminates status asthmaticus. This observation has led many to use induced fever as one of the methods of treatment in the more severe, unyielding types of asthma.

Postmortem examination in these types of cases in which death has occurred from accident, or an unrelated pathologic condition, has revealed the accumulations of mucus in the bronchial tree to which we have directed attention. We refer to the chronic, low grade fever, and the more acute type as well, as "plug pneumonitis" or "obstructive pneumonitis," whichever seems to fit the elegance of the moment. One must realize, too, that patients in this category may also have rheumatic or undulant fever, tuberculosis, Loeffler's syndrome, or blood dyscrasias. They may harbor parasites, abscessed teeth, or diseased tonsils. Hence, we cannot overemphasize the point that there is no substitute for complete, careful, rational clinical investigation and evaluation.

In adults this picture is further complicated by the ever present menace of neoplastic diseases of the lung, primary or metastatic. The first indication of a tumor of the lung, especially of the bronchus, may be a pneumonitis, an infection which may be cleared up by the use of antibiotics and/or sulfonamides. Alveolar carcinoma and lymphomatous disease of the lung may, in the allergic person, suggest Loeffler's syndrome, and one cannot afford to be caught off guard by failing to give these patients the benefit of thorough roentgen, endoscopic, and if necessary, biopsy investigation.

Therapy

If, after probing the chest complaints of the wheezing, dyspneic allergic patient, one returns to the initially presumptive diagnosis of asthma, what then is the guide to treatment? This is a large question, but one to which, for an audience of allergists, there are workable answers. We must assume that all discoverable allergic, structural, and infection factors have been reckoned with. Feathers and dust have been controlled, bronchostenosis and bronchiectasis have been ruled out, and the maximum possible cognizance of emotional elements has been taken. In the middle life and late life groups we must still be sure to determine the circulatory factors in the dyspnea. Has there been arteriosclerosis, hypertension, or coronary or cardiac valvular disease? If so, are these complicating the disease picture?

Of most help to us has been the simple calcium gluconate, or decholin (if patient has received digitalis), arm-to-tongue circulation time. In the emphysematous chest we have found this value to be 8.0-12.0 seconds, whereas in the cardiac dyspneas in which there is no doubt as to the cause, as in failure of the left side of the heart,

the time is 22.0 up to 34.0 seconds. The average normal is 12.0-18.0 seconds, and if in an asthmatic patient the measured time lies even in the middle of this range, we begin to suspect a circulatory factor. In such instances cardiac support may be indicated with digitalis or dehydration, as the case may be. Mercuhydrin is of great value in reducing congestion and lightening the load otherwise left for allergic management alone. If the strain on the right side of the heart has proceeded to great lengths and cor pulmonale is a growing problem, a sympatholytic or adrenergic blocking agent has been useful in some instances. We have used dibenamine[3] in this manner, as reported last year at the meeting of the American College of Allergists in St. Louis. This drug blocks the pressor and constrictor effects of adrenalin without interfering with its well known inhibitory effects, such as bronchial and coronary relaxation. In selected cases this drug has proved a useful adjunct to our therapeutic measures.

Of late, the appearance of ACTH and cortisone, and their availability for general use in allergic states, initially at least suggested that all refinements in therapy might quickly go into the discard. As more has been learned of these truly miraculous drugs, their limitations and drawbacks have also become more evident. It is true that on occasion these hormones produce a prompt and most satisfactory remission, but we are nevertheless left with the same primary problems that we had prior to the discovery of Kendall and Hench. We are learning that there is no royal road or easy path to successful diagnosis and treatment in asthma. All the investigative acumen of the observer must continue to be brought to bear on this age-old problem. The "cure" remains the desideratum, and seems most likely to be achieved through the sound pathologic physiologic approach which can only be derived through training and seasoned experience in this challenging field.

Summary

We have discussed some of the problems confronting the physician who deals with chest complaints and asthma in allergic children and adults. It is suggested that psychosomatic factors may stem from rather than produce the allergic complaint, and might be considerably reduced if the child gained the benefit of earlier, more accurate diagnosis and treatment. Unexplained fever in many of these youngsters has been found to be due to plugs of mucus obstructing small segments of the lung causing, in some instances, "plug" or "obstructive pneumonitis." In adults, however, one must be on the alert for neoplasms of the bronchi and lungs before establishing the diagnosis of allergic pulmonary disease.

In managing asthma in older adults, the measurement of the circulation time has been of great help in evaluating the role of hemodynamic factors, and in properly directing the treatment toward correction of fluid balance and of heart failure, in addition to the usual allergic therapeutic measures. In cor pulmonale the use of dibenamine, a sympatholytic, adrenergic blocking agent, has proved useful in selected cases. Despite the newer hormone drugs which are gaining wider use, the older therapies based on sound pathophysiologic principles, thorough training, and seasoned experience, are still the treatment of choice in the management of allergic diseases.

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2. Bozalis, G. S.: Proceedings Balyeat Hay Fever and Asthma Clinic 20:11 (Nov.) 1950.

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740 Magnolia Avenue.

MEDICAL DISTRICT MEETINGS

The Chairman of the Council, Dr. William C. Roberts, has announced that the dates of the Four Medical District meetings have been officially set by the Council.

Every member of the Association is urged to attend the meeting in his district and any of the other three meetings as desired.

Pensacola, Oct. 22, 1951

Bradenton-Sarasota, Oct. 24, 1951

Vero Beach, Oct. 25, 1951

Orlando, Oct. 26, 1951

ABSTRACTS OF MEDICAL ARTICLES

A POSITION OF VALUE IN STUDYING THE PELVIS AND ITS CONTENTS. By Gerard Raap, M.D. South. M. J. 44:95-99 (Feb.) 1951.

Dr. Raap observes that it seems scarcely conceivable that the Chassard-Lapine position has not been used and referred to more often in the voluminous literature on radiology since the French authors for whom it is named first described it in 1923. He states the conviction that it can be shown to have many uses. For example, in urology it will be of value in demonstrating the ureters and their relationship to the bladder with asymmetries due to adjacent tumor locations, and in hysterosalpingography it will give added information as to the shape and size of the uterine cavity and the location of the ovaries.

His chief interest, however, lies in its use with reference to the colon, particularly that borderline area between the realm of the radiologist and that of the proctologist, and he was unable to find previous mention of its use in this respect. The inclusion of at least one study of the colon in the Chassard-Lapine position has become a routine procedure in his work because of the fact that it often proves suspicious areas of incomplete filling to be normal, thereby making the diagnosis more positive than without it.

FAILURES IN MEDICAL TREATMENT OF PEPTIC ULCER, AN ANALYSIS OF INTRACTABILITY AS AN INDICATION FOR SURGERY. By Donald F. Marion, M.D. South. M. J. 44:148-153 (Feb.) 1951.

In a review of all operations for peptic ulcer performed during a recent twelve month period in two of Miami's larger general hospitals, intractable pain was the sole reason for operation in 20, or 29.4 per cent, of the 68 cases. The author cites lack of firmness on the physician's part and inability or unwillingness on the part of the patient to give intelligent cooperation as sharing responsibility to a considerable degree for failure of medical treatment. He notes that evaluation of the patient's inability to cooperate reveals a high incidence of both psychotic and seriously neurotic persons in this group. Also, he warns that a high incidence of suspicion must be maintained for hidden anatomic complications since in 60 per cent of the cases in this series such lesions were present at operation.

In view of the frequency of anatomic complications, Dr. Marion regards a standard or modified subtotal gastric resection as the procedure most likely to give prolonged freedom from pain and to restore a normal productive life to the patient. He believes that "intractability should not continue to be a wastebasket catch-all and an excuse for backing reluctantly into the operating room, but a comprehensively analyzed complication of peptic ulcer which receives the same thoughtful and skillful surgical treatment required by pyloric obstruction, acute and chronic perforation, and serious hemorrhage."

PAROXYSMAL VENTRICULAR TACHYCARDIA WITH SECOND DEGREE V-A BLOCK AND RECIPROCAL RHYTHM. By Sidney Grau, M.D., and James L. Gouaux, MD., Circulation 2:422-425 (Sept.) 1950.

A case of paroxysmal ventricular tachycardia with retrograde conduction is reported. The patient was an elderly white man in the terminal stage of arteriosclerotic heart disease. The electrocardiograms obtained during this period, representative portions of which are illustrated, were unique in that both reciprocal beats and fusion beats were noted during the tachycardia. The latter were unusual because of the origin and site of the fusion of the impulses within the ventricles. Also described and illustrated is a hitherto unreported abnormality of the retrograde P wave.

THE HEART IN FRIEDREICH'S ATAXIA. By M. Eugene Flipse, M.D., Thomas J. Dry, M.B., and Henry W. Woltman, M.D. Minnesota Med. 33: 1000-1003 (Oct.) 1950.

The literature is reviewed which emphasizes the involvement of the heart in Friedreich's ataxia, and 2 cases of this disease in association with myocarditis, occurring in brothers aged 18 and 12, are reported. An absence of tendon reflexes and an extensor response of the plantar reflex, the two neurologic signs most frequently observed in patients with electrocardiographic abnormalities, were present in both cases. These cases represent another example of the observation that afflicted members of one family tend to have similar electrocardiographic patterns.

The authors offer no explanation for the more pronounced electrocardiographic changes present in the younger patient, in whom neurologic damage was less evident, but they emphasize it because it is contrary to previous experience. In this latter case, there was extension of electrocardiographic abnormalities across the entire precordium, a finding which further supports the belief that most, if not all, of the cardiac abnormalities associated with Friedreich's ataxia are due to a diffuse myocarditis, of unknown but probably toxic origin.

A NEW APPROACH TO THE TREATMENT OF SUBCAPITAL AND TRANSCERVICAL FRACTURES OF THE HIP, PRELIMINARY REPORT. By Eugene L. Jewett, M.D., F.A.C.S., F.I.C.S. J. Internat. Coll. Surgeons 14:403-419 (Oct.) 1950.

Dr. Jewett reports on a method of treating subcapital and transcervical fractures of the hip in which he initiated the use of a one piece of flanged hip nail for fractures about the trochanteric region. After trial of a year and a half, he finds the results promising. The series of 14 consecutive cases represents approximately one fourth of the 54 cases of fracture of the femoral neck or the trochanteric area in which he has operated during this period. He explains the cardinal points which justify use of this nail and presents roentgenograms of the entire series.

URETERAL INJURY COMPLICATING FRACTURE OF THE BONY PELVIS. By Arthur J. Butt, M.D., and Joseph Q. Perry, M.D. South. Surgeon 16:1139-1142 (Dec.) 1950.

The lack of a "typical" early picture of ureteral injury complicating pelvic fracture may account, in the opinion of these authors, for the few cases of this type reported in the literature, and their true incidence is possibly greater than is generally assumed. In the case of ureteral injury complicating pelvic fracture which they report, apparently the ureteral and periureteral tissue at the level of the pelvic brim was contused and lacerated by fractured bones, and a dense periureteritis and ureteral stricture, producing hydronephrosis and hydroureter, developed. Plastic repair of the ureter was deemed impossible; the kidney and upper two thirds of the ureter were therefore removed.

CLINICAL EXPERIENCE WITH CROWE'S VACCINE IN THE COMBINED MANAGEMENT OF ARTHRITIS. By Kenneth Phillips, M.S., M.D. South. Med. & Surg. 113:68-71 (March) 1951.

In the opinion of this author Crowe's vaccine presents a well tried and valuable measure at the hands of the general physician to combat rheumatic disease. In his experience it stands out as first choice of any single measure in the management of this disease. Its value, however, will be in direct ratio to the amount of attention paid to the basic concepts and technic in its use, which he discusses. When lack of response is evident, he favors combination with sulfur, gold, physical or fever therapy to effect a definite gain in symptomatic relief. Cortisone, while observed by him for only a short time, has proved itself, at least temporarily, superior in the true rheumatoid type; it has not equaled the other measures in either the mixed or nonrheumatoid cases. Physical therapy is a valuable adjunct in many cases, he noted; when indicated, it should be used in combination with other selected measures. Fever therapy, by electromagnetic induction, in short sessions, will often supplant other physical measures when many joints are involved, but as a specific, it has shown no value in his hands except in arthritis of gonorrheal origin.

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August Anniversaries

AUGUST 1. Joseph Priestley isolated oxygen on Aug. 1, 1774. A voluminous writer with a passion for experimentation, this ardent nonconformist clergyman was the founder of the Unitarian Church in the United States.

Although Priestley did not perceive the true nature of respiration, he told Lovoisier of his experiments with oxygen. Later, Lovoisier settled the question.

AUGUST 1. John Collins Warren was born on Aug. 1, 1778 and died on May 4, 1856. In contrast to his father, Dr. John Warren, who had only apprentice training, Dr. John C. Warren had the advantage of study in London, Edinburgh and Paris. Parallel to the work of his father, who founded the Harvard Medical School, Dr. John C. Warren founded the Massachusetts General Hospital in 1821. It was he who made it possible for Morton to try ether anesthesia on patients undergoing general surgery.

AUGUST 2. John of Gaddesden, England, who lived during the thirteenth and fourteenth centuries, was probably the original of Chaucer's Doctor of Physic. John's training at Merton College, Oxford, which embraced four years of study after the M. A. degree and included much practice in Latin disputation, did not require that he watch even one dissection, see a single patient, or do one bit of clinical work. John, however, became a popular practitioner as well as physician to Edward II. He was appointed to a stall in St. Paul's Cathedral on Aug. 2, 1342. It was prior to that time that he was chosen by Chaucer as a member of that oddly assorted company which assembled at the Tabard Inn in Southwark on the old Roman road for the pilgrimage to Canterbury. In later years John found time, despite a large practice, to write a popular medical text, Rosa Medicinae or Rosa anglica, made up largely of kitchen lore, superstitions and medical quotations.

AUGUST 11. Richard Mead of London, born on Aug. 11, 1673, was the second possessor of the famous gold-headed cane, bequeathed him by Radcliffe. Scholarly, courtly, popular and wealthy, Dr. Mead was physician to Queen Anne and to George II. He made a study of smallpox inoculation in 1721, three quarters of a century before Jenner's work. He might be called the father of English quarantine, for believing the plague at Marseilles, France, to be contagious, he induced the English government to establish its first quarantine. Among other outstanding accomplishments, he persuaded the wealthy citizen, Guy, to establish the famous hospital named after him.

On disarming "Dr. Woodward," a colleague, in a duel, Dr. Mead exclaimed, "Take your life!" Woodward is said to have responded, "Anything but your physic."

Dr. Samuel Johnson said, "Dr. Mead lived more in the broad sunshine of life than almost any man."

August 24. Pliny the Elder, Gaius Plinius Secundus, greatest of Roman natural philosophers, was born in the first quarter century after Christ and died in the eruption of Vesuvius on Aug. 24, A.D. 79. Pliny was a student in the true sense of the word. He always made notes when he read, he had a servant read to him while he bathed, dressed and ate, and he had a secretary at hand almost constantly who took dictation on wax tablets. He wrote voluminously on diverse subjects, leaving to posterity a thirty-seven volume Natural History notable for the section which deals with zoology. Pliny was an outstanding student of medical botany. In philosophy he was a "modified stoicist;" in his view of nature he was pantheistic. His nephew and heir, Pliny the Younger, described his uncle's death in a letter to Tacitus; hence we know the date and circumstances of his death. To watch the eruption of Vesuvius more carefully, Pliny and a group of friends landed from a ship on the south shore of the Bay of Naples. Apparently to escape the approach of fire, ashes, lava and showers of stones, Pliny lay down on the seashore. His body was found free from burns or other injuries. Apparently he had been suffocated by fumes.

August 29. Oliver Wendell Holmes, physician, poet and Autocrat of the Breakfast Table, was born in Cambridge, Mass., on Aug. 29, 1809. His great contribution to the medical world is his essay, "On the Contagiousness of Puerperal Fever," read on Feb. 13, 1843, before the Boston Society for Medical Improvement and published that year in volume I of the New England Quarterly Journal of Medicine and Surgery. This paper is a milestone in the history of medicine and in the attitude of physicians toward infection.

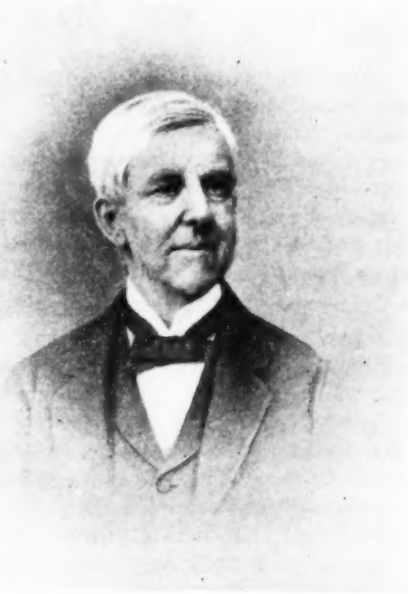
Puerperal fever had been recognized from the earliest days of medicine. Hippocrates and Galen both were acquainted with the symptoms and signs of the disease.

At about the time Dr. Holmes was collecting material for his essay, a young undergraduate in medicine in far-off Vienna, Ignaz Philipp Semmelweis, was making independent observations on the contagiousness of puerperal fever. In 1847, four years after Dr. Holmes presented his essay, Dr. Semmelweis composed his first treatise on the subject.

To Dr. Holmes, of course, goes the honor of priority, but Dr. Semmelweis deserves to have had his name made famous because of his recognition of the disease as a septicemia and because of his unceasing teaching. Dr. Frank Slaughter in a recent historical novel, "Immortal Magyar," has given full impact to the drama and tragedy which enveloped Dr. Semmelweis' life, particularly toward its end.

After Dr. Holmes had brought forth strong proof of the contagiousness of puerperal fever, his views were not readily accepted by many. He was attacked by the two leading obstetricians of Philadelphia, Drs. Meigs and Hodge, who believed that "irregularity of diet, a confined state of the bowels" or "atmospheric changes" were responsible for the disease.

Because of the small circulation and early discontinuance of the journal in which his paper was published and because of the controversy which was aroused, Dr. Holmes had his paper republished in 1855, the introduction to which every student of medicine should read.



Yours truly
Oliver Wendell Holmes

(Courtesy: Volume I, Medical Classics, Baltimore, The Williams & Wilkins Company.)

Sir William Osler once asked Dr. Holmes whether he valued more his paper on puerperal fever or his poem, "The Chambered Nautilus." Replied Dr. Holmes, "There is . . . a nobler satisfaction from the life-saving labor."

Hungary has honored Dr. Semmelweis by removing his ashes from Vienna and burying them with ceremony in Budapest and by erecting in one of the public squares of Budapest a fine monument to its son. The United States has yet to honor Dr. Holmes befittingly.

The Korean Medical Experience

Once they reach medical care, fewer wounded American soldiers are dying in Korea than in World War II. The mortality now appears to be less than 2½ per cent as compared to 4 per cent in World War II. The rate in World War I was approximately 8 per cent.

This lowered death rate is attributed in part to the increased number and further uses of the antibiotics, such as penicillin, chloromycetin, aureomycin, streptomycin and terramycin. During World War II, penicillin was the only one of these drugs available, and it was not available throughout the entire Army medical system until late in the war.

Transfusion of whole blood is also a contributing factor in the lowered mortality. First used in the last war, whole blood has been available since the beginning of the Korean operation and is administered in the forward areas. Dextran, polyvinylpyrolidone and gelatin are being used to combat shock due to injury, but these substitutes can never replace blood plasma or whole blood.

Methadon, a synthetic morphine substitute, has been proved to have, dose for dose, the same pain-killing effect as morphine and also causes far less nausea and vomiting. Chloroquin, the new drug to combat malaria, is proving effective as a suppressant and much more desirable than atabrine. It is given only once a week. While it does not produce clinical cure of malaria, it is effective against the malaria-bearing parasites in the blood stream. The Army is also testing primaquin, another new drug, with the expectation that it will effect clinical cure.

A new type of dressing for extensive body burns, a pad 3 by 2 feet, has on the side touching the patient a fine gauze covering backed up by many sheets of an impermeable material resembling facial tissue. Also receiving extensive testing is a bandage with a two way stretch which is chemically treated to make it self adhering.

ACTH is being used in the treatment of burns and frostbite, and in wounds where the nerves have been injured. Scar tissue, which makes surgical repair of nerves difficult, is prevented by ACTH.

These highlights of the Korean medical experience were presented before the recent convention of the American Pharmaceutical Manufacturers' Association in Boca Raton by Col. Lawrence A. Potter of the Army Surgeon General's Office, whose comprehensive article entitled "What Medicine Has Learned in Korea" was published in the April issue of the Journal of the American Pharmaceutical Association.

A Decade of Health Progress in Florida

Tremendous progress was made in the general field of health in Florida during the period from 1940 to 1949. The highlights of the picture presented by Dr. Wilson T. Sowder, State Health Officer, at the annual meeting of the Association in April should afford great gratification to every member.

A highly significant evidence of progress was the 15 per cent decline in the over-all death rate. Down in varying and in some instances truly remarkable degree were the maternal and infant death rates and death rates from infectious diseases and other causes. The mortality from diphtheria, whooping cough, typhoid fever, dysentery, malaria and typhus fever (combined) was down appreciably. The decrease by one half in the death rate from tuberculosis was in contrast to a considerable increase in the death rate from cancer.

The great decline in mortality from syphilis caused it to be replaced by diabetes in the first ten causes of death. The death rate from pneumonia and influenza also greatly decreased. That the combined mortality from cardio-vascular-renal diseases did not increase suggests, as Dr. Sowder observed, that in some measure the increase in heart disease may be due to changing fashions in diagnosis.

There was a gratifying decrease in the motor vehicle accident death rate and also in the mortality from other accidents.

The increase in hospital beds about paralleled the increase in population. Here the increase of 117 per cent in the number of bassinets and of 91 per cent in the number of beds for tuberculous patients is particularly noteworthy.

While the problems of the decade of the fifties are pressing and offer abundant challenge, nevertheless the accomplishments of the forties may well be a source of great pride to Dr. Sowder, his staff and the members of the Association. They provide ample incentive for the future.

Novel Diagnostic Method

A good way to discover what is wrong with patients is to imitate them. This "diverting, medically useful, life hobby" was described in California Medicine for January 1950 by Dr. C. M. Cooper, retired professor of clinical medicine at Stanford University. Imitating the gestures, postures and facial expression of patients and then figuring out what would produce them might be as profitable a diagnostic procedure in Florida as in California.

There was the patient who thought he had gallstones. When he got down on his hands and knees and inclined his body to demonstrate the position which relieved his pain, Dr. Cooper did the same, imitating his every movement. His conclusion that the posture he had assumed seemed more calculated to afford some relief from pain originating in the kidney rather than in the gallbladder was confirmed by roentgen examination. Imitating a patient's expression, gait or idiosyncrasies afforded valuable clues to other illnesses.

Told early in his career that he was a poor clinical observer, this resourceful physician began dividing up a patient's face into sections, examining each section individually. Soon he was catching expressions that formerly eluded him. If he could not arrive at their meaning, he would imitate them before a mirror. Then would come realization of what inner feeling in him would have called forth such an expression, and in all likelihood in the patient exhibiting it. Before long he was imitating the tone, placement and tempo of the speaking voice and eventually the behavior reactions of his patients.

Revealing experiences with patients made it but a step to extend these activities into the imaginative or experimental fields. "Thus I would imagine I had a particular symptom or ailment that puzzled me," said Dr. Cooper, "and then see if I could uncover anything in my past that might cast light upon it; or that I had a patient's crippling impairment for which he had not been able to evolve a helpful compensatory adjustment; and then try through self experimentation to unearth one for him."

Putting himself in the patient's place, so to speak, might well prove stimulating physical and mental gymnastics for the clinician. Too, this vicarious approach to the patient's problem might greatly increase his diagnostic acumen.

The War Prisoner Medical Burden in Korea

American medical personnel in Korea has indeed had thrust upon it "an unusual burden" in giving outpatient and hospital care to more than three quarters of a million enemy prisoners of war. The Department of the Army has announced that in a recent six month period Army hospitals in Korea received as patients 37,000 North Korean and Chinese Communists, in addition to 800,000 given outpatient treatment.[1] To another 179,416, vaccinations and immunizations were administered. Despite this monumental task, the mortality among hospitalized enemy prisoners was only 7 per cent, as compared with a death rate of 8 per cent among American wounded receiving medical attention in World War I. Yet the Army report states that "great complications" were present in a majority of enemy cases treated.

The many diseases encountered among the enemy troops, the apparent indifference of the enemy to caring for battle casualties, the low and often nonexistent standards of medical care provided by the enemy for their own casualties, little or no provision for drugs, equipment or evacuation of casualties, utter indifference to the value of human life with wounded men left to die without treatment of any kind, all of these factors greatly enhanced the difficulties of the United States Army Medical Service. Even at best, says the report, standards of treatment have been low in the Communist forces, with undergraduate medical students serving in most medical officers' positions.

1. Care of War Prisoners in Korea, J. A. M. A. 146:13 (June 23) 1951.

The Florida Cancer Council

It has become increasingly apparent to many physicians of Florida engaged in the various aspects of cancer work that there is a need for an over-all co-ordinating body to unify and help determine the shape and direction of cancer control in Florida. One phase of the cancer control program has been administered by the Florida State Board of Health, another has been handled by the Florida Division of the American Cancer Society, and some phases have not been attended to by any agency. There has been no direct tie-in between the American Cancer Society, the Florida State Board of Health, and the Committee on Cancer Control of the Florida Medical Association. In short, the cancer control program of Florida has been deprived of its maximum effectiveness because of the lack of co-ordination and direction.

In 1950, representatives of the Committee on Cancer Control of the Florida Medical Association, the Florida State Board of Health, and the American Cancer Society, realizing these deficiencies, began to discuss the desirability of forming an over-all committee which would correlate and give direction to the cancer control program of the state. About the time these plans began to take form, a letter came from the American College of Surgeons suggesting that, if no statewide cancer control committee existed in Florida, one be set up by the College. The reasons establishing the desirability of this committee were set forth by the College and these reasons coincided exactly with what those of us in Florida had been thinking. Many states, notably Texas and New Jersey and our neighboring state of Georgia, had already organized cancer control committees which were functioning to the advantage of these various states.

With this encouragement, a definitive plan was formulated in Florida which envisioned a seven man committee to act as a statewide cancer control committee. The membership was constituted as follows: two members from the Florida State Board of Health, two members from the Committee on Cancer Control of the Florida Medical Association, two members (physicians) from the Florida Division of the American Cancer Society, and one member representing the American College of Surgeons. In order to avoid confusion with any existing cancer committee, it was decided that the committee would be called the Florida Cancer Council. Each participating organization has since approved the Florida Cancer Council and named its representatives. The Council became official when approved by the Florida Medical Association at its annual meeting in Hollywood in April 1951.

The present membership of the Florida Cancer Council is as follows:

Representing the American Cancer Society

Dr. Ashbel C. Williams, Jacksonville, President, Florida Division, Chairman*

Dr. C. Frank Chunn, Tampa, Director, Tumor Clinic, Tampa Municipal Hospital

Representing the Florida Medical Association

Dr. Frazier J. Payton, Miami, Chairman, Committee on Cancer Control

Dr. George W. Morse, Pensacola, Member, Committee on Cancer Control

Representing the Florida State Board of Health

Dr. Wilson T. Sowder, Jacksonville, State Health Officer

Dr. Lorenzo L. Parks, Jacksonville, Director, Cancer Control Program

Representing the American College of Surgeons

Dr. Duncan T. McEwan, Orlando

The Council is working on a Cancer Control Program for Florida at the present time. The various phases of this Program will be presented in The Journal as each phase is completed. The help of and suggestions from all the physicians of Florida are earnestly solicited by the Council. Already the Council has brought about a spirit of cooperation amongst its parent organizations.

It is hoped that the efforts of the Florida Cancer Council will meet with maximum success and that every physician in Florida will do his bit to make the Cancer Control Program outstanding. The Florida Cancer Council needs the understanding and support of every member of the Florida Medical Association in order to carry out its program and attain its objectives.

*Chairman elected by the members of the Council.

The National Fund for Medical Education

In a determined effort to meet voluntarily the critical financial needs of the nation's hard-pressed medical schools, industry, organized labor, agriculture, universities and scientific and educational foundations have recently joined hands with the medical profession. Establishment of the National Fund for Medical Education was announced in New York in May at the annual meeting of the sponsoring group.

The board of trustees of this important new organization is composed of 66 of America's most distinguished leaders. Former President Herbert Hoover is serving as honorary chairman and Mr. S. Sloan Colt as president. Mr. Colt is the president of the Bankers Trust Company of New York. On the 20 man advisory council are presidents of leading universities and members of the Council on Medical Education and Hospitals of the American Medical Association and of the executive council of the Association of American Medical Colleges.

The Fund has for its chief objective the raising annually of substantial sums from voluntary sources in order to relieve the acute problem faced by medical schools as they endeavor to maintain high academic standards in the face of crippling budgetary problems. The goal for the first year is $5,000,000, and emphasis is being placed on obtaining contributions from corporations and organized groups, now the great potential source of philanthropy in this country. In announcing the Fund after two years of careful planning and organization, Mr. Colt stated that the initial support had come from a wide spectrum of the American community, including contributions from the medical profession and such other groups as 18 leading life insurance companies and many industrial corporations, providing starting resources of more than $1,000,000.

A minimum goal of $1,000,000 is suggested for the medical profession for this year as evidence of its willingness to meet its responsibilities in this combined effort. Anticipating the day when the profession would be called upon to participate in this project, the American Medical Association last December appropriated $500,000 as a nucleus for the profession's 1951 contribution and at the Cleveland meeting sponsored the founding of the American Medical Education Foundation, through which individual physicians and state and county medical societies could make their contributions. The Foundation has announced that it will channel its contributions from physicians through the Fund, thereby demonstrating the importance it attaches to this movement and the confidence it has in its success.

Physicians are expected to continue making their contributions to the American Medical Education Foundation, 535 N. Dearborn St., Chicago 10. These contributions to the Foundation will be turned over in lump sums to the Fund, which is not assuming the responsibility of handling the individual contributions. A novel feature of the Fund's machinery is that every dollar in contributions flows directly into medical education because the administrative costs of the Fund have been underwritten by a number of foundations; also, appropriate provision has been made for equitable distribution of the money. The arrangements between the Foundation and the Fund make full and adequate provision for handling directed contributions. Physicians may continue to designate the school to which they wish their contributions to go and may be assured that the schools will be notified of the names of the contributors and the amounts contributed.

The Fund now provides the vehicle through which all who are concerned for the welfare of the nation's medical schools, whether organizations, groups or individuals, may assist in solving this vital problem. While the medical profession continues aggressively its intensive effort to do its part in this nationwide drive to meet the needs of the medical schools on a national basis, individual physicians can render important service not only by contributing liberally but also by encouraging lay interest, especially among officers of companies and corporations.

Pertinent lay comment follows:

Mr. Hoover characterized the organization of the Fund as a "significant development in the strengthening of the nation's medical manpower."

Dr. James B. Conant, President of Harvard University: "One of the Fund's most appealing features is that it has brought together men of widely differing backgrounds and personal viewpoints to concentrate their energies on a problem which, if left unattended, may well help to destroy many of America's private universities."

Dr. Harold E. Stassen, President of the University of Pennsylvania: "Doctors are on the front lines of our national defense effort and they must

be competently trained along present high standards if we are to maintain our leadership in world affairs."

Mr. Colt: "The Fund is a fine example of practical democracy at work. . . . What is most gratifying and significant is the fact that this vital project has brought together as trustees a broadly representative group of men and women. Those who organized the Fund may have differing social viewpoints but, insofar as the Fund is concerned, we have united in an endeavor to solve a serious problem for the common good. Unless the medical schools are given financial help, and given it quickly, the standards of medicine may be permanently impaired and the nation's health affected adversely."

Postgraduate Medical Education

A course in Hematology presented by the Department of Medicine of the Graduate School of the University of Florida was given by Dr. Charles A. Doan, Dean and Professor of Medicine at the Ohio State University College of Medicine, Columbus, Ohio, June 21-23, 1951, at the George Washington Hotel in Jacksonville. Registration for this course was 81. The interest in the course was keen. Dr. Doan was an enthusiastic lecturer holding his audience throughout the entire period.

* * *

The Nineteenth Annual Graduate Short Course, meeting June 25-30, 1951, was also held in Jacksonville at the George Washington Hotel. The registration was 171.* The lecturers were excellent and well received by those in attendance. Dr. A. A. Marchetti, the lecturer on Gynecology, had an unfortunate accident to his knee and was unable to attend. Dr. Bayard T. Carter, Professor of Obstetrics and Gynecology at Duke University School of Medicine, Durham, N. C., agreed to substitute at the last minute. He took the subjects already assigned to Dr. Marchetti. The Committee regrets deeply that Dr. Marchetti could not be present and is most grateful to Dr. Carter for coming to the rescue so ably.

*Thirteen Negro physicians.

YOUR BLUE SHIELD

Blue Shield Name Becomes Official

The official names of the Florida Blue Cross and Blue Shield Plans have been changed from Florida Hospital Service Corporation and Florida Medical Service Corporation to Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc., respectively.

The change became official and effective on June 19, when amendments to the charters of both plans, proposing to change the names of the corporations, were approved by Judge Bayard S. Shields, Circuit Judge of Duval County, and recorded in the office of the Clerk of the Circuit Court for Duval County. Prior approval of the amendments had been received from the Insurance Department of the State of Florida.

The name change will in no way affect the administration of the Plans, and has no significance other than the inclusion of the terms "Blue Cross" and "Blue Shield" in the official names of the corporations.

Such a step had been under consideration for several months by the Boards of directors of the two plans because of the common useage and close association of the terms "Blue Cross" and "Blue Shield" with the two health care plans, and because of the advisability of registering these terms and their identifying emblems with the Secretary of State as protection against possible use by other parties.

The term "Blue Cross" and the Blue Cross emblem signify the seal of approval of the American Hospital Association which is given annually only to those non-profit, voluntary hospital care plans which meet the standards set up by that association. The Florida plan has received the American Hospital Association's approval each year since its organization in 1944.

"Blue Shield" is a similar identification for the voluntary, non-profit medical care plans.

In order to eliminate any expense in connection with the name changes, the printed forms and letterheads showing the former names of the two corporations will be used until the present supply is exhausted.

STATE BOARD OF HEALTH

Immunization Procedures

The State Board of Health is frequently called upon by physicians of the State and County, and Health Directors, for an immunization schedule for various age levels. The State Board of Health has recently prepared a schedule for immunizations. The schedule in the table below is recommended provided alum precipitated or alum hydroxide absorbed is used. The schedule is submitted as information for the readers of The Journal.

The State Board of Health is attempting to purchase biologicals whereby the standard dosage will be 0.5 cc. The dosage in some products may differ from this amount. This schedule was designed to fit the need of Health Officers doing mass immunizations and may not necessarily fit the needs of private physicians who are able to give more individual attention to each patient.

Recommended Immunization Schedule

Biologicals	Age	Dose	Booster
Diphtheria, Pertussis, Tetanus (DPT)	2-4 months up to 5 years	0.5 cc.—3 doses one month apart	12-18 months after completed series. 2-3 years later and again in 3 years
Diphtheria, Tetanus (DT)	2-4 months up to 5 years	0.5 cc.—2 doses one month apart	Use single antigen
Diphtheria Toxoid	2-4 months up to 8 to 10 years	0.5 cc.—2 doses one month apart	One year later and/or on admission to school
Pertussis Vaccine	2 months up to 6 years of age	0.5 cc.—3 doses one month apart	3 or 4 years later up to 6 years of age
Tetanus Toxoid	2 months up to any age	0.5 cc.—2 doses one month apart	1 year after series and every 3-4 years after injury
Smallpox	Preferably after DPT and at all ages		Every 3-4 years and on exposure
Typhoid	Not recommended routinely except in endemic areas and upon exposure	0.5 cc.—3 doses 1 to 3 weeks apart	Every year

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Asher, Leo A., Jr., Miami
Beller, Harry E., Miami
Breakstone, Judd R., Miami Beach
Cole, Benjamin M., Orlando
Feldman, Leon R., Miami
Griffitts, John J., Miami
Hasty, Frederick E., Coral Gables
Kaye, Harry D. L., Miami
Rudolph, Jack A., Miami Beach
Shapiro, Richard D., Miami Beach
Turnley, William H., Ocala
Verdon, Franklyn E., South Miami

BIRTHS AND DEATHS

Births

Dr. and Mrs. David Kirsch of Miami announce the birth of a daughter on June 15, 1951.

Dr. and Mrs. Daniel R. Usdin of Jacksonville announce the birth of a daughter, Lauren Harriet, on June 18, 1951.

Dr. and Mrs. Maurice I. Edelman of Miami Beach announce the birth of a daughter, Denise Gail, on June 25, 1951.

Deaths — Members

Howard, Everett E., Gainesville ..... May 14, 1951
Jones, Gerald W., Orlando ..... June 5, 1951
McGunagle, Joseph E., Miami ..... June 5, 1951
Powell, Jay A., West Palm Beach ..... July 2, 1951
Counts, Herbert W., Jacksonville ..... July 4, 1951

Deaths — Other Doctors

Kenworthy, William B., Lake Worth ..... March 19, 1951

STATE NEWS ITEMS

The annual district meetings for 1951 have been scheduled as follows: Northwest District A at Pensacola, October 22; Southwest District C at Bradenton-Sarasota, October 24; Southeast District D at Vero Beach, October 25, and Northeast District B at Orlando, October 26.

The program for these meetings will be arranged by Dr. William C. Roberts of Panama City, chairman of Council. He will be assisted by the eight councilors and the secretaries of the cooperating county medical societies. The complete program will appear in a later issue of The Journal.

The Southern Medical Association has scheduled its forty-fifth annual meeting at Dallas, Texas, Nov. 5-8, 1951.

Members of the Florida Medical Association who will participate in the meeting include Dr. Walter C. Jones, Miami, first vice president; Chadbourne A. Andrews, Tampa, councilor; Sullivan G. Bedell, Jacksonville, chairman of the section on neurology and psychiatry, and J. Randolph Perdue, Miami, chairman of the section on gynecology.

Dr. Joshua C. Dickinson of Tampa served as chairman of the section on radiology at the 1951 annual meeting of the American Medical Association, Atlantic City, June 11-15.

Dr. DeWitt C. Daughtry of Miami has recently been elected president of the Florida Chapter of the American Trudeau Society.

Dr. Paul W. Hughes of Fort Lauderdale on June 25 addressed the West Hollywood Citizen's league on the subject, "Health and Sanitation for Unincorporated Areas."

Dr. John T. Stage of Jacksonville was the guest speaker at the Gainesville Rotary luncheon on June 20. Dr. Stage spoke on the history of anesthesia.

Dr. Maurice I. Edelman announces the opening of his offices at 515 N. E. 15th Street, Miami. His practice will be limited to Ear, Nose, Throat, Bronchoscopy and Plastic Surgery.

Dr. Robert H. Hutchinson of Tallahassee recently addressed the Florida State Nurses Association on the contributions of early orthopedic physicians.

Dr. M. Austin Chardkoff of Tampa has returned to his practice following a visit to medical clinics in Chicago.

Dr. Donald W. Smith of Miami served as chairman of the dedication committee of the Dade County Cancer Institute, which was held on July 2-3.

Dr. F. Gordon King of Jacksonville recently received his Master of Medical Science in Surgery degree at the University of Pennsylvania.

Drs. Gunnard J. Antell and Wesley S. Nock announce the opening of new offices at 273 Alhambra Circle, Coral Gables. Their practice will be limited to pediatrics.

Dr. Jack L. Wright of Miami has returned to his practice following a tour of active duty as a reserve officer with the Navy Medical Corps. He was released to inactive duty June 10, 1951 with the rank of Lieutenant Commander.

Dr. Philipp R. Rezek of Miami presented a paper, "Hormonal Influences upon Cancer of the Prostate," before the recent meeting of the International Association of Medical Pathologists which was held in London.

Dr. Sullivan G. Bedell, Jacksonville, spoke to the Big Brothers at a recent luncheon meeting at the local First Christian Church.

Dr. Hubert A. Barge of Miami was recently honored by being chosen the "outstanding alumnus of Mercer University for 1951."

Dr. Arthur J. Butt of Pensacola was guest speaker at the National Colloid Symposium held recently at Cornell University, Ithaca, New York. He spoke on "Importance of Urinary Colloids in Prevention of Kidney Stones."

Effective June 7, Mrs. Arthur E. Curtis will be full-time Field Representative of the Association's Bureau of Public Relations to work in Southwest and Southeast Medical Districts. For the past two years, Mrs. Curtis has been on a half-time basis in the Dade County area.

Dr. Edward V. Pollard of St. Petersburg on June 7 addressed the graduating class of the Mound Park School of Nursing.

Dr. Harold E. Winchester of Dunedin conducted a quiz program at the regular meeting of the local Rotary Club on June 7.

Dr. Robert J. Jahn of Winter Haven recently addressed the meeting of District 12, Florida State Nurses Association, which was held at the Winter Haven Hospital. Dr. Jahn discussed new drugs and various ways of administering them.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

WANTED: Recent medical school graduate with one or two years internship for employment in office of general surgeon in central Florida. Write 69-52, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: New W-666 Castle Autoclave 8"x16", $250.00; chrone outside; steam jacket; bronze cast body; double Full-Automatic control (pressure and low water cut-off). Contact John F. Mason, M.D., 120 Walcaid Building, Bradenton, Fla.

COMPONENT SOCIETY NOTES

Dade

The Dade County Medical Association held its regular monthly meeting at the Miami Woman's Club on July 3. The program included a symposium on cytology.

Escambia

Members of the Escambia County Medical Society participated in the annual Escambia Medical Assembly held in Pensacola June 15. This yearly medical program is held in conjunction with the Fiesta of Five Flags. Speakers on the full day program included Drs. Raymond B. Squires, Alpheus T. Kennedy, Alwyn W. White, William J. Overman and Pascal G. Batson, Jr., all members of the society.

Guest speaker was Dr. R. L. Sanders, professor of surgery at the University of Tennessee College of Medicine.

Marion

At the regular monthly meeting of the Marion County Medical Society on June 19, Dr. Robert B. McIver, president-elect, spoke on "Congenital Anomalies."

Orange

All members of the Orange County Medical Society have paid their state dues for 1951.

MEDICAL DISTRICT MEETINGS

The Chairman of the Council, Dr. William C. Roberts, has announced that the dates of the Four Medical District meetings have been officially set by the Council.

Every member of the Association is urged to attend the meeting in his district and any of the other three meetings as desired.

Pensacola, Oct. 22, 1951

Bradenton-Sarasota, Oct. 24, 1951

Vero Beach, Oct. 25, 1951

Orlando, Oct. 26, 1951

OBITUARIES

George Lewis Hardgrave, Jr.

Dr. George Lewis Hardgrave, Jr., of Jacksonville was killed in a plane crash on Iwo Jima on April 22, 1951. He was 34 years of age. Interment took place in Clarksville, Ark., on June 1.

A native of Arkansas, Dr. Hardgrave was born in May 1916 in Clarksville, where his father, Dr. George Lewis Hardgrave, Sr., is still engaged in the practice of medicine. After graduation from the Clarksville High School, he received his premedical training at the College of the Ozarks and the University of Arkansas, where he received the degree of Doctor of Medicine in 1942.

Upon completion of an internship at St. Luke's Hospital in Jacksonville, Dr. Hardgrave reported for active duty with the United States Navy in 1943, serving in the Caribbean, Mediterranean and North Atlantic theaters. He completed his training as a flight surgeon in Pensacola in 1944 and served as flight surgeon at Litch Field until his separation from the service in 1946.

Following his military service, Dr. Hardgrave returned to Jacksonville to enter the private practice of surgery. From July 1946 to July 1947 he served as extern in surgery at St. Luke's Hospital.

On Dec. 5, 1950 he returned to active duty as flight surgeon in the United States Navy and was stationed in Japan. Four months later he met death in the service of his country.

A member of the Duval County Medical Society, Dr. Hardgrave also held membership in the Florida Medical Association, the Arkansas Medical Society and the American Medical Association. He was a member of the Phi Chi medical fraternity and of the American Legion, and was a Thirty-Second Degree Scottish Rite Mason.

Surviving are the widow, Mrs. Betty Hardgrave, and two daughters, Nancy and Mary Ann. His parents, three sisters and two brothers also survive.

Horace Rainsford Drew

Dr. Horace Rainsford Drew of Jacksonville died at his home on May 28, 1951 at the age of 74 years.

Born in Jacksonville on July 6, 1876, Dr. Drew was the son of Horace Drew and Gertrude Fairbanks Drew and the grandson of Columbus Drew, founder of the H. & W. B. Drew Company, and of Major George Rainsford Fairbanks, one of Florida's pioneer historians. After completing his early education in his native city, he attended the University of the South at Sewanee, Tenn., where he received the degree of Doctor of Medicine in 1901.

Returning to Jacksonville, Dr. Drew engaged in the practice of internal medicine and enjoyed a distinguished career for almost half a century. In the Spanish-American War he served with the Jacksonville Light Infantry. In 1916 he was elected to the Associate Staff of St. Luke's Hospital, ten years later became Chief of the Department of Medicine there, and in 1933 was made Chief of Staff. For many years he was prominently identified with Jacksonville activities and was a member of the Seminole Club and the Florida Yacht Club. He was a communicant of St. John's Cathedral. He remained in the active practice of medicine until January 1950.

Dr. Drew was a member of the Duval County Medical Society, of which he was a past president. He was for forty-six years a member of the Florida Medical Association and had for eleven years been a life member. He was also a member of the American Medical Association.

Survivors include the widow, Mrs. Louise Phillips Drew; a son, Horace Rainsford Drew, Jr., of Jacksonville; a brother, Rutledge D. Drew of Island Grove; a granddaughter, Shelley Louise Drew; a grandson, Robert Fairbanks Drew; a half-brother, Hodson Drew; and a half-sister, Mrs. Marguerite Drew Bardin, all of Jacksonville.

Joseph Elmer McGunagle

Dr. Joseph Elmer McGunagle of Miami died at his home on June 5, 1951 after an illness of several weeks. He was 65 years of age.

Dr. McGunagle was born in Mt. Clemens, Mich., and received his early education in Detroit. He was awarded the degree of Doctor of Medicine from the Vanderbilt University Medical School in 1912 and engaged in postgraduate work in New York City.

From 1916 to 1919 Dr. McGunagle practiced medicine in Daytona Beach. He then located in Miami, where he continued to practice for thirty years. His specialty was surgery. He was a communicant of SS Peter and Paul Catholic Church.

Dr. McGunagle was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Gertrude McGunagle; a daughter, Mrs. Mary G. Brion; and a son, Joseph A. McGunagle, all of Miami; three brothers, George McGunagle of Mobile, Ala., and Alfred and Art McGunagle of Wyandotte, Mich.

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From where I sit *by* Joe Marsh

Hope "Cappy" Told Him Where To Get Off!

"Cappy" Fisher—who just retired after thirty-five years as a railroad conductor—was talking the other day about a salesman who was often one of his passengers.

"That man was so busy," says Cappy, "he used to bring a dictaphone on the train to catch up on his letters. On one trip he'd been rushing around so much he clean forgot to bring his ticket. Left it on his desk."

When Cappy started to tell him not to worry about the ticket, the salesman busts out with "Who's worried about the ticket? It's just that now I don't know exactly what city I was going to get off at!"

From where I sit, there *are* people who get so wrapped up in themselves and their ideas they forget "where they're going." Some get so narrow they would tell a man where and how he should practice his profession . . . others would deny their neighbors the right to a glass of beer. Just as trains run on steam and oil, democracies run on freedom!

Joe Marsh

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"When One Hand Washes the Other; Both Can Wash the Face"

Last month, I spoke of the executive turnover of Auxiliary officers on the state and county levels, and of the necessity of keeping in touch during that transition for smooth and continued operation of the organization. For, at each annual state meeting, all counties attend the meeting to report on their achievements; the sum of which constitutes the progress of the state.

This month, all state auxiliaries, including Alaska and Hawaii attended the annual national meeting and the states reported; the sum of which constituted the progress of the Nation in auxiliary activities.

I was proud to report for Florida. Out of thirty six county medical societies we have nineteen auxiliaries with an increase of membership to total 936.

Our program for the past year, self education of the individual and active participation of the auxiliary member in community activities, resulted in better relations and improved communities throughout the state, and was instrumental in achieving the following benefits:

A special series of evening programs at the Woman's Club in Tallahassee, the capitol city, on American citizenship. The history of America was brought up to date by authorities on history, law and economics.

A hookworm survey of a whole community was spearheaded by auxiliary members through a

woman's club and was cited in a national magazine as outstanding.

We have a $1,000 Nurse Scholarship Loan Fund to be used for matching county funds for nurses seeking R. N. specialized training or a Bachelor of Science in nursing at Florida State University.

The philanthropies throughout the state range from a $1,582.99 project for furnishing a premature ward in one group, to a "sunshine committee" which operates to cheer the aged in convalescent homes with personal visits and gifts.

Counties were outstanding in getting "Today's Health," the health magazine of the A.M.A. before the public, and in participating in every health drive and civic need. These and other individual contributions through auxiliary work gave Florida a place of dignity when states reported.

We had seven delegates present out of the nine permitted by our total membership. New York had thirty-eight present. For every one hundred members we have one vote. As our efforts to organize the seventeen remaining counties yield results our voting delegation will increase.

Every new auxiliary represents a new found spring of public relations for the doctor, from which will emanate a refreshing source of good will and creative value to the community.

The membership of the National Auxiliary has reached 57,448. There were four hundred more delegates this year than last.

To be part of this vast organization, whose object is to extend the aims of the medical profession to all organizations which look to the advancement of health and health education, is a privilege.

I will continue to extend a sincere invitation to all doctors' wives to join us in our wholehearted support of Dr. John W. Cline, President of the American Medical Association; and Mrs. Harold Walquist, President of the National Auxiliary in their efforts to preserve freedom in American Medicine.

Mrs. C. Robert DeArmas
President

Ambulance Service

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GYNECOLOGY—Intensive Course, Two Weeks, starting September 24, October 22. Vaginal Approach to Pelvic Surgery, One Week, starting September 17, November 5.

OBSTETRICS—Intensive Course, Two Weeks, starting September 10, November 5.

MEDICINE—Intensive General Course, Two Weeks, starting October 1. Gastroenterology, Two Weeks, starting October 15. Electrocardiography & Heart Disease, Two Weeks, starting October 22.

UROLOGY—Intensive Course, Two Weeks, starting September 24.

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BOOKS RECEIVED

MASTER YOUR MIND. By Samuel Kahn, M.D., Ph.D. Pp. 262. New York, Rockport Press, Inc., 1951.

This book is written to appeal to "students, teachers, businessmen, parents, social workers and other intelligent people who are interested in mental efficiency engineering, both for themselves and for guiding others."

Formerly Clinical Professor of Neurology and Psychiatry at Georgetown and George Washington Universities, and now of the Department of Psychology and Psychiatry of Long Island University, Dr. Kahn draws upon wide experience in teaching and in handling and guiding many normal and abnormal people to make this book practical and helpful to those genuinely interested in helping themselves and others to be successful. Among the subjects he discusses are the understanding of the conscious and unconscious mind, the principles of child guidance and dynamic psychology, the economy and hygiene of learning, memory methods, study habits, health practices, causes of success and failure, the building of personality and character, attitudes and efficient habits and activities. For more serious students, there are chapters which deal with note taking, library methods, bibliographic methods, and mental and psychologic philosophies.

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